Lessons Learned: A Qualitative Study of School Social Workers' Experiences Providing Crisis Response and Recovery After Targeted Gun Violence

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ABSTRACT

Objective: Targeted gun violence in schools, once uncommon tragedies, are now regular occurrences in the United States. Since 2018, there have been 533 incidents of gun violence in schools that resulted in death or injuries (Everytown for Gun Safety, 2022). Crisis response and recovery for these school communities are lengthy. Community crisis response teams often assist school districts in the immediate response; however, responsibility for immediate and ongoing interventions often falls onto the school-based mental health professionals, particularly social workers. Minimal empirical data is available regarding the experiences of "emotional first responders," and no studies address school social workers specifically, who are personally and professional impacted by these events. This qualitative study examined the lessons learned from school social workers providing crisis response and recovery to school communities impacted by mass targeted gun violence. Specifically, this study sought to understand how school social workers navigate providing support that is often beyond their explicit roles in the school while experiencing and managing the impacts of trauma for themselves and in their communities.

Method: The researcher used grounded theory methodology to learn from the experiences of 12 MSW-prepared school social workers employed by an impacted school district at the time of mass targeted gun violence or contracted in the immediate aftermath of the shooting. Multiple participants from three school districts were recruited to prevent one single point of view. Each participant completed two semi-structured interviews at two- to four-week intervals to examine their personal and professional experiences during the crisis response and recovery. The researcher used semi-structured interview guides designed to elicit experience and meaning making around additional responsibilities, crisis response preparation, and the ability to manage personal and professional impact of the trauma. Specific questions about prior training elicited perceptions on levels of confidence in crisis response and recovery skills. Data analysis used the constant comparative approach, consistent with grounded theory, to complete open and thematic inductive coding and theoretical coding grounded in systems theory and relational cultural theory concepts.

Findings: All participants discussed the importance of connection or relationship with colleagues, students, administration, and families in the response and recovery process. Students, staff, parents, and social workers all worked toward reconnection after unimaginable violence shattered the perceived safety within their workplaces and their communities. Connection through processing and supervision were critical especially in the management of STS and VT symptoms. These connections further assisted with relational resilience and empowerment as the communities moved through the phases of crisis response and recovery. Participants reinforced that response and recovery is an ongoing endeavor that requires intervention on multiple systems levels. The magnitude of the trauma often requires social workers to assume additional responsibilities outside their normative scope of practice. Participants felt their MSW education, specifically field education, provided adequate preparation for basic crisis response, but lacked the specialization to provide recovery support around the intensity of targeted gun violence-related trauma and the needs across systems in

recovery and rebuilding efforts. The need and challenge of seeking out sufficient self-care for social workers also emerged.

Discussion and Implications: School social workers reported varied preparation and supports as they navigated the intersection of professional and personal trauma in the context of complex school, community, and political systems. Important factors for managing personal impact included supervision that provided both the opportunity to connect with colleagues to process/debrief their feelings and clinical case support consultation to minimize professional risk. Professional systems of support, including predictable schedules for debriefing and formal school sponsored self-care activities, should be included during the workday to improve access and engagement. To address the expressed need for more specialized training, findings suggest that CSWE may consider developing content or require MSW programs to offer course and experiential work in crisis intervention techniques, such as Psychological First Aid, to assist social workers with identification of trauma reactions and associated treatment skills with the theoretical underpinnings for their use.

Conclusion: The findings highlight the importance of connection and growth-fostering relationships in crisis response and trauma recovery. These findings also support previous research which indicated social workers and other emotional first responders are at high risk for secondary traumatic stress (STS) and vicarious trauma (VT). The implications of these findings extend beyond the social work profession and to first responders within other disciplines who are exposed to trauma in their work responsibilities. The findings also include social work education implications, specifically a gap in knowledge pertaining to more specialized crisis intervention skills.

Keywords: *school social work, social work practice, gun violence, trauma, crisis response and recovery, self-care, debriefing, social work education*

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DEDICATION

This dissertation is dedicated to those students and staff who were injured or whose lives were cut short by gun violence. It is also dedicated to the families who have experienced incredible grief from these horrific tragedies and to those in the helping professions who responded in the aftermath with such support and compassion. Finally, it is dedicated to those impacted communities that were forever changed by this unimaginable violence.

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CHAPTER ONE

Introduction

Overview

On April 20th, 1999, two students at Columbine High School in Colorado murdered 12 classmates and one teacher as well as injured 24 additional students and faculty. Although school shootings date back to the 1800s, this was the first K–12 mass targeted shooting in which the students tactically planned the massacre and in which the national media recorded the aftermath of the tragedy in real time. The images of students running from the school building with their hands raised above their head – an unseen and shocking sight for many at the time – is unfortunately now an all-too-common occurrence. On December 14th, 2012 a 20-year-old man walked into Sandy Hook Elementary in Newtown, Connecticut with a semiautomatic rifle and murdered 26 people. The victims included 20 first grade students ranging in ages from 6 to 7 years old and six faculty members. Another deadly school shooting occurred on February 14th, 2018 at the Marjory Stoneman Douglas (MSD) High School in Parkland, Florida. At 2:19 p.m., a former student entered school building #12 with a semiautomatic rifle with multiple magazines and proceeded to pull the fire alarm. As the hallways flooded with students evacuating the building, he murdered 17 people and injured an additional 17 individuals. This was the first school shooting that was captured on video in real time. The videos were posted on social media and replayed through media outlets igniting national outrage and vows from politicians that this should never happen again. But it did – Sante Fe High School, Great Mills High School, STEM School, Saugus High School, Oxford High School. Outrage and disbelief turned into a sense of inevitability over the last decade.

Those aforementioned school shootings, in particular, have become indelible images in the minds of many due to the real time national coverage and horrific nature; however, every

year in the United States, schools experience gun violence. In 2018 alone there were 25 school shootings killing 56 people and an additional 86 incidents at schools involving a firearm (Gun Violence Archive, 2014–2018). Since 2018, there have been 547 school shootings that resulted in at least one death (Everytownresearch.org, 2022). These disturbing statistics indicate that this violent trend is continuing and even increasing.

Social workers at these districts provided ongoing support to their school community. From crisis intervention in the immediate aftermath to providing long-term social emotional support to the entire community, school social workers have been called upon to serve multiple roles in addition to their traditional school social work responsibilities. Many have provided these crisis response and recovery services to others despite also being exposed to this shared trauma.

K–12 School Landscape for Social Workers

The K–12 school landscape and the responsibilities of the school social worker have changed significantly over the last 20 years in the United States. School social workers are required to be well-versed in human development and federal education policy in order to effectively support students with Individualized Education Plans (IEPs) and 504 plans; however, they are also tasked with the responsibilities of addressing social and emotional issues impacting student learning. The School Social Work Association of America (SSWAA), a prominent national professional organization for school social workers, described the school social work role as encompassing the following responsibilities: mental health and behavioral intervention/counseling, classroom and academic supports, consultation support for parents and educators, and assistance with creating an environment that supports the school district's mission for the school (SSWAA, 2020). These responsibilities alone are a daunting task given the

overwhelming psychosocial need, high social worker to student ratio, and the limited support resources within K–12 schools (Walkley & Cox, 2013). School social workers employed by school districts that have experienced targeted gun violence are often also tasked with guiding and leading the recovery efforts in addition to their typical day-to-day responsibilities. Additional responsibilities within the recovery effort could include additional student support during the school day, serving as an active member of the school crisis team that provides support to families, faculty, staff, and the larger community, or in a macro social work capacity guiding administrators with service delivery, policy changes, and memorialization events. This is a tremendous workload given the number of students that the average school social worker is responsible for within their district.

School Social Work Standards and Certification

The 2012 NASW Standards for School Social Work Services recommended that the social worker to student ratio should be 1 worker per 250 students, and that there should be a social worker in each school building. Unfortunately, there are no states meeting this standard. The national average is 1 social worker to 2,106 students (US Department of Education, 2016). In fact, states such as WA (1:14,391), Nevada (1:8,730), and California (1:6,132) far exceed the recommended standards. The ACLU compiled a report from the 2015–2016 Civil Rights Data Collection by the US Department of Education which revealed the followings statistics: approximately 67,000 schools nationwide reported no school social work services available to students and only 3,000 schools nationwide complied with the recommended ratio of 1 social worker to every 250 students. A major contributor to this problem is the lack of uniform federal standards allowing states to dictate their current social worker/student ratio (Mumm & Bye, 2011). The aforementioned ACLU report expressed concern that many districts focused more on

punitive responses to psychosocial need with a focus on school resource officers than on hiring mental health professionals such as social workers. The result is schools without adequate support services and school social workers who are overwhelmed by the number of students on their caseload. In addition to the overwhelming number of students on their caseload, social workers are also experiencing significant numbers of students with mental health concerns.

School Social Workers and Student Mental Health

A 2019 NAMI report cited that 1 in every 6 youth (age 6–17) will experience a mental health condition. Approximately, 4.4 million US children age 3–17 have been diagnosed with anxiety and approximately 1.9 million have been diagnosed with depression (CDC, 2017). These numbers only reflect the children who have had access to treatment and who have been officially diagnosed. Of concern are those students who have been silently experiencing symptoms of anxiety and depression without intervention or those students displaying behavioral disorders manifesting from these untreated conditions. It is not surprising that the rates of suicide and homicide in this age group have increased. The Center for Disease Control (2017) reported that the suicide rate increased by 70% from 2006 to 2016 for children ages 10–17 years old. The homicide rate for 15–19 years old also tracked by the CDC has fluctuated since 2000; however, since 2014 it has increased by 30%. The implications of these increasing rates and their prevalence within the 10–19 age range would indicate that schools are likely feeling the impact of these tragic deaths.

Approximately 72% of US children have experienced some type of traumatic event by the time they are 18 years old (Whitaker et al., 2019). This can include both accumulative and acute trauma experiences. In addition to the trauma history students may bring to school with them, the school environment can activate and exacerbate symptoms secondary to sound

sensitivity, large crowds of people, and safety drills such as active shooter drills. The school environment can also cause trauma through such experiences as bullying, aggressive behavior, and violence. School social workers in addition to their counseling colleagues in guidance and psychology, are often tasked with developing behavior plans and offering supportive counseling to these students to mitigate the impact of trauma and mental health conditions upon their learning.

School Shootings and Student Mental Health

The day-to-day responsibilities of social workers are amplified after targeted gun violence as the numbers of students impacted are greater and the trauma is often more acute. The implications of targeted gun violence in schools can be short-term and temporary for some students and have long-term impact on others (Ruzek et al., 2007). The mental health impact can vary depending on an individual's supports and resources as well as their proximity and relationship to the shooting and the victims. Strozier (2011) in a post-9/11 study characterized these as the "zones of sadness". Lowe and Galea (2017) conducted a systematic review on the mental health consequences of mass shootings and identified a variety of risk factors to victims including shooting exposure (proximity and relationship), pre-existing mental health conditions, and a lack of support. Through the examination of 49 peer-reviewed articles on 26 independent samples of 15 mass shootings, the authors noted that "exposure to assaultive violence or learning that a close friend or loved one has faced such exposure, is associated with an increased incidence in negative mental health outcomes among them Major Depressive Disorder and Post-traumatic Stress Disorder" (Lowe & Gala, 2017, p. 62). In addition this systematic review revealed there is an increase in both individual and community fear around safety. Crisis response and recovery requires knowledge of both micro and macro trauma responsive

interventions. School social workers are often trained on the accumulative trauma students present with, but are they trained to provide crisis response and recovery services?

Implications for MSW Education

Although many MSW programs provide school social work specific coursework as well as general trauma coursework, CSWE-accredited MSW curriculums in the United States rarely provide school social work students with specific trauma-informed school social work training with both micro and macro interventions (CSWE, 2019). Providing support and intervention around mental health is significantly different than providing either crisis response or trauma-responsive interventions. There is currently no foundational training delivered in MSW curriculums or through state school credentialing programs that provides social workers with school-specific crisis and trauma responsive trainings. Universities such as Rutgers University and New York University offer post MSW certification in trauma and crisis response, but it does not appear to be school social work specific. The University of Southern California is reportedly developing a school social work certification that includes school-based crisis and trauma interventions.

Given the overwhelming psychosocial need and the prevalence of trauma in the school setting, trauma responsive school social work training is essential to prepare our future school social workers. This qualitative study seeks to explore the experiences of social workers who have been employed at a school district at the time that targeted gun violence occurred or social workers were contracted/hired in the immediate aftermath to provide crisis intervention and ongoing recovery services. This grounded theory qualitative study with social workers who provided crisis response and recovery services in the aftermath of a targeted gun violence in their

district will serve as an impetus to further examine how to improve educational programs that prepare school social workers for practice.

CHAPTER TWO

Review of Literature

Relevant School Gun Violence Research

This literature review will provide an overview of relevant literature pertaining to crisis response after targeted gun violence in schools, with a specific focus on school social work. For the purposes of this dissertation, the term "targeted" gun violence will align with the US Secret Service definition of when an "attacker selects a target prior to the attack" (National Threat Assessment Center, 2019). Review of social work and relevant school mental health literature revealed a significant gap in research pertaining to school social workers' crisis response experiences post targeted gun violence. The majority of available literature with regard to school social work and trauma pertained to Adverse Childhood Experiences (ACEs) and not gun related violence. There is research that focuses on targeted gun violence; however, the central theme of these studies has pertained largely to assessment and prevention of violence rather than on examining the experiences of crisis and support workers in the aftermath.

It is noteworthy to add that the majority of school related gun violence literature has been published since the Columbine shooting in 1999 and has focused on white middle- to upper-class communities despite gun violence being a well-documented occurrence in lower socioeconomic communities and in communities of color. The literature that has documented response services post shootings contains primarily first-person narratives that are nonempirical in nature or studies that focus on exploration of school-based mental health professionals rather than specifically school social workers. A few of the published papers have described experiences of school-based counselors or the experiences of community providers who were "on-site" support briefly after the shootings. There is a significant lack of literature – both empirical as well as first-

person narratives – that focused on school social workers' experience providing crisis response. This dissertation aims to learn about the experiences of school social workers providing services after targeted gun violence occurred at their school sites.

One of the first and most pivotal studies post-Columbine that examined the impact of gun violence in schools on school personnel in the United States was conducted at four school sites that experienced targeted gun violence. This study included Columbine High School. The study focused on the impact of the tragedy on school leadership, specifically their ability to lead and the emotional toll (Fein, 2001). This study was later expanded into three qualitative studies interviewing 36 participants in seven North American schools that experienced targeted gun violence between 1996 to 2002. These qualitative studies examined the experience of school leaders in the aftermath regarding how their work changed during that period, their definitions of leadership, and the emotional impact of leading during such a significant crisis (Fein, 2001; Fein et al., 2008; Fein & Isaacson, 2009).

Forty-five unstructured interviews of the 36 participants were conducted with the primary question, "What was it like for you to serve in a leadership role during the school shooting crisis?" Of note and of direct implication to this study are the following themes: lack of organizational violence information in their graduate level training programs, the emotional impact of providing support, and the utilization of school mental health professionals. Some participants reported that they would avoid interactions that required the provision of significant emotional support and would assign those responsibilities to school mental health professionals. While interviewing school administrators, Fein (2001) recognized the trend of administrators yielding or assigning informal leadership roles to mental health professionals. As a result, several school-based mental health professionals were included in the study due to their informal

leadership roles. Fein et al. (2008) reported a lack of adequate preparation or training for school counselors to assume supportive leadership roles, especially as the findings reveal that school leadership relied significantly on school counselors in the immediate aftermath of the shooting. These novel roles often required them to perform responsibilities outside of their scope of knowledge including involvement with the media, executive decision making, and crisis management policy decisions. Fein et al. (2008) posited administrators assigned school counselors these tasks because of their secondary skill set of effective communication, empathy, and interpersonal skills.

Fein et al. (2008) also reported school counselors assumed multiple roles outside of the normative day-to-day responsibilities to address targeted gun violence, and the need to prioritize crisis management-oriented interventions. In addition to taking the lead on Crisis Response Teams, school counselors frequently engaged in informal counseling and trauma debriefing for faculty, staff, and administrators. School counselors who participated in this study acknowledged their awareness of the risk of secondary traumatic stress, but decided, or didn't consider the extent to which, the needs of students and faculty superseded their own personal risk of a trauma response. Fein et al. (2008) highlighted that formal stress debriefing was common for traditional first responders, but not a component of crisis response in educational settings. This study is significant because the participants were part of the school community impacted by the violence and were tasked with assuming leadership roles when they were also experiencing the emotional toll of a tragedy. Although this study explored the experience of school counselors and school leaders after mass shootings, the role of the school social worker was not specifically explored, nor was their preparation or training to provide supportive services post trauma.

Crepeau-Hobson et al. (2012) reiterated many of Fein et al.'s (2008) themes, including the lack of appropriate training for school mental health professionals around crisis intervention and trauma reactions preventing school leadership from effective decision making. The four authors on this paper were all members of the Colorado Society of School Psychologists Statewide Crisis Team and among them have responded to three school shootings including Columbine High School. One of the authors reportedly provided crisis intervention services after *all three* school shootings. From their collection of first-person narratives of experiences providing crisis response post targeted school shootings, they suggested several lessons critical in crisis response for schools; however, the article is more narrative in nature and lacks empirical rigor. The first and most relevant to this proposed qualitative dissertation is the authors' concern that school and district mental health professionals have not received appropriate training to effectively respond to mass trauma events (Crepeau-Hobson et al., 2012). They advocated for having crisis preparedness plans in place preventatively as well as ensuring that school mental health professionals are adequately trained in school-specific crisis response. The authors specifically detailed the NOVA trauma response model (Young, 1998). This model was utilized in response to all three shootings to address direct support services including triaging, long-term support, and systems-level interventions involving communication with the community and the media. Crepeau-Hobson et al. (2012) noted that every school crisis response will vary based on the size of the school, its culture, the community, and the nature of the trauma; therefore, a range of services and supports should be offered to students, teachers, staff, and the community. In designing interventions, Crepeau-Hobson et al. (2012) suggested initial crisis responders consider: the length of services needed, the availability of community based mental health professionals, the size of the school impacted, the nature of the community impact, and whether

the shooting involved fatalities. The importance of informal connections was highlighted in particular for high school students in the immediate aftermath.

> Following a major crisis, students often want to be together and share their stories in an informal manner. This is especially true of secondary school students. We have found high school students tend to seek each other out and cluster with their peers. Middle school students are more likely to want to be with their parents and other Supportive adults in addition to their peers. (Crepeau-Hobson et al., 2012, p. 216)

Although this article provided importance guidance in effective crisis response procedures post school shootings, their narrative focused more on the logistical aspect of the response and less on the emotional impact on school mental health professionals. The idea of secondary traumatic stress was cursively mentioned with regard to leadership responses and the importance of allowing crisis responders the opportunity to debrief. Their procedurally-focused observations may be attributed to the authors being external to the school community directly impacted by the shootings. In addition, the authors are not school social workers but, rather, school psychologists with a different theoretical training. Although the observations of these crisis response professionals are compelling, the journalistic nature of their findings also lacked the empirical support.

Similarly, Hagman (2017) in *Helping Newtown: Reopening a School in the Aftermath of Tragedy,* shared his first-person experiences as an external crisis responder providing support following targeted gun violence at Sandy Hook Elementary School. As a licensed clinical social worker, he provided his observations through a strength-based social work perspective. The narrative of his article was based on the reported experiences of the entire crisis response team; however, the case narrative was presented entirely from Hagman's point of view. The

Connecticut Disaster Behavioral Health Response Network Team (DBHRN), of which the author is a member, was activated the day of the Sandy Hook School shooting with the intent of short-term crisis intervention to provide stabilization with the goal of the school returning to full educational functioning. The article detailed his experiences and observations leading the crisis response team.

Hagman (2017) discussed utilization of the crisis intervention, Psychological First Aid (PFA) in the work with students, parents, and staff. One reason PFA was reportedly selected was that it aligned with the psychoanalytical idea of Winnicott's (1965) safety of the "holding environment". The second core component of PFA is establishing safety and comfort – a critical part of any trauma intervention. Hagman (2017) shared that his experience was that trauma and grief responses are unique so it is essential to assist with establishing a social context that supports people through this process. He offered the idea that the school system, the actual building, and the relationships within the community provided the space for grieving.

> It offers a social milieu to process suffering, allows many the opportunities for contact, to share feelings, and give meaning to the experience, and assures the survivors that the integrity of the community and its social structures can survive and offer hope.
>
> (Hagman, 2017, p. 170)

The importance of relationships was emphasized as the author cited Geist's (2008) statement that "true healing requires connectedness". The DBHRN crisis team using a relational approach when attempting to restore stabilization within the school buildings. The school community's sense of certainty and safety had been impacted by the shooting, so it was imperative that the crisis team establish a stability. The author applied the concept of "zones of sadness" when working with a community impacted by mass tragedy. Strozier (2011) developed

this concept in his study of post-9/11 experiences by characterizing trauma responses into descriptive categories of proximal impact. Zone 1 includes individuals whose lives were directly in danger from the event; Zone 2 includes those who observed the event; Zone 3 includes those who experienced indirect but significant impact from the tragedy; and Zone 4 includes those individuals impacted by the images and the media surrounding the trauma. Strozier's use of the zones accurately described the impact of physical and emotional proximity to the crisis; however, the term "sadness" inadequately captures the extraordinary and pervasive trauma experienced after mass targeted gun violence. Therefore, for purposes of this study any reference to the zones will not include "sadness".

Hagman (2017) noted the following observations about the zones as it pertained to the students, parents, staff, and community reactions: student and staff reactions varied based on their exposure to the shooting and their relationships to the victims (Zones 1–3); parents sought guidance about how to discuss this with their children and support around the loss of safety in school (Zones 3–4); teachers struggled with their own trauma and grief, but were expected to resume teaching (Zones 1–3); and the community as a whole was significantly impacted (Zones 1–4). The author offered a word of caution that "destructive emotions can be activated" in communities and systems that experience significant trauma through "an intrusive media, political decision making, and labor relations problems" (Hagman, 2017, p. 174).

Utilizing the zones analogy has been useful to evaluate not only Hagman's narrative, but also all previous studies pertaining to the traumatic impact of school shootings. The DBHRN crisis team studied consisted primarily of individuals classified in Zone 3 or Zone 4; however, it was noted how impactful the work was on these clinicians. The team reportedly met as a group in the morning frequently to express their own feelings and emotions around the response. The

work of the DBHRN crisis team was short-term in nature so a relational approach assisted with rapid rapport building, but also opened them to greater risk of Secondary Traumatic Stress. In order to fully support the school, the team established relationships with not only the students, but the administrators, staff, parents, and the entire community. The goal of their short-term crisis response work was to prepare the community for more in-depth grief and trauma work through community providers.

> It was our job to restore confidence, give hope, and support the mobilizing of healthy defense. Our goal was not to resolve the morning and trauma but to set up the conditions where others would do this. (Hagman, 2017, p. 174)

Although this single case narrative provided a compassionate perspective on the aftermath of a mass tragedy in addition to beneficial crisis response guidance, the narrative was from external providers who were only present for a short period of time rather than school-based mental health professionals with a history of working within the community impacted by the trauma. Also, the author was a clinical social worker; however, it was not stated whether the entire crisis team were social workers or whether other mental health disciplines were involved.

Day et al. (2017) conducted a qualitative study with a focus on shared trauma of clinicians after the Virginia Tech shooting. This was a phenomenological case study that focused on eight clinicians within the Virginia Tech community who provided services following the 2007 shooting. The term "clinicians" encompassed multiple mental health disciplines including both Masters- and Doctoral-level practitioners. The study did not indicate the specific disciplines and degrees of the clinicians. The clinicians provided direct support to those who both directly and indirectly experienced the shooting. The clinicians were either employed on campus or practiced within the local community. Utilizing the zones concept, the clinicians in

this study would likely fall within Zone 3 as indirectly or directly being impacted by the tragedy as college campuses are often expansive and the counseling centers are typically housed in separate buildings. In addition, several of the clinicians in this study were community clinicians and not employed on Virginia Tech campus. The Day et al. (2017) study is one of the few studies that has examined the delivery of crisis intervention services by mental health clinicians who lived or worked within an impacted school community. Day et al. (2017) defined shared trauma as "occurrences in which the clinician and client are simultaneously exposed to collective trauma" (p. 217).

Researchers conducted semi-structured interviews using a two-tier phenomenological approach with the participants to ascertain both the context and the meaning making of their experiences. The study examined the professional terminology they used to characterize their traumatic responses including "vicarious traumatization," "compassion fatigue", "vicarious resilience", and "posttraumatic growth". Findings revealed that many clinicians were hypervigilant in their recognition of potential symptoms due their own personal trauma history; however, many clinicians experienced difficulty maintaining professional and personal balance in their lives in the aftermath. Half of the respondents in the study reported they understood the importance of self-care, yet they prioritized the needs of their clients over their own. The idea of providing services while not adequately being able to self-care was a theme previously identified in both Hagman's (2017) article detailing the Newtown response and Fein et al.'s (2008) article on the Colorado school shootings.

Day et al.'s (2017) research participants reported relying on relational techniques such as empathic connection to foster connection with their affected clients. This study provides important insight into the experience of mental health providers who maintained the dual role of

providing services while also sharing the trauma of the mass shooting. The authors asserted that the clinicians were extremely suspectable to vicarious trauma due to the shared trauma and the level of empathy required from mental health professionals in a crisis response role. Empathy was identified as a critical component of the therapeutic relationship, but also a "connection" that placed clinicians at higher risk for developing vicarious trauma; therefore, boundary management is essential. Day et al. (2017) suggested the importance of setting personal and professional boundaries as a professional necessity, especially given the shared trauma experiences by the Virginia Tech clinicians. Boundary setting and self-care are not new practices within the clinical realm as many practitioners gravitate to the field secondary to their own lived trauma experiences. The hope is that clinicians have been able to process their own lived trauma prior to their practice or during training so as to mitigate overidentification or the risk of causing harm to clients. The unique aspect of mass trauma is that both the clinician and the client could be experiencing a trauma response from the shared experience. Findings revealed the following common themes among clinicians: boundaries can become challenging due to the high numbers of students and staff in distress, difficulty with vicarious trauma due to the shared commonalities of the experiences, limiting social media and media about the shooting, and distrust of media intrusion and coverage of the tragedy.

Day et al. (2017) indicated that the clinicians provided service immediately after the shooting as well as on an ongoing as needed basis; however, it is unclear whether the treatment extended into the recovery phase. It may have been valuable to explore the difference, if any, in the length of services and the emotional impact on the clinicians as well as how the clinician's educational training prepared them to provide trauma-focused interventions. This researcher's study explored the experience of school-based social workers who provided services

immediately after targeted school gun violence as well as ongoing support post crisis. This provided the opportunity to evaluate the influence of the passage of time from crisis response to recovery.

There is a significant lack of relevant literature, specifically empirical work, related to the experiences of school based mental health practitioners who serve in the dual role of both provider and member of a community who has experienced targeted gun violence. This study on Virginia Tech clinicians provided the closest match regarding the impact of a shared trauma experience; however, the data did not reveal any implications on whether the clinicians' education and training provided the skills necessary to provide crisis-based services.

Although the Day et al. (2017) study explored the experiences of this dual role, it did not specifically focus on the experience of the school social workers and it was not focused on the K–12 school setting. In fact, only one study, Brown (2019), focused on the experiences of the K–12 school counselors post targeted gun violence in schools. Brown (2019) conducted a case study to explore the experiences of school-based counselors who experienced an on-site school shooting. Brown's study focused on the experiences of three participants although eight individuals working at the school at the time were interviewed to allow for different perspectives of the school response. The three participants included two former elementary school counselors and the middle school counselor. The focus of the research was to understand the way in which counselors' skills and decisions were perceived after a "rampage" killing. In this research study Brown (2019) defined "rampage killing" as "an act of violence by a student or previous student intending to cause harm to multiple people at their school at random" (p. 3). The study identified several themes that echo other literature, including the concern about the lack of professional preparation/training around specific crisis response techniques, the importance of professional

relationships and collaboration when providing crisis response, the emotional response to the shared trauma, the increased responsibilities in their roles, and the importance of self-care (Brown, 2019). The author noted participants discussed the importance of relationships, both professionally with regards to collaboration with peers and from a micro perspective providing support to students, faculty, and parents. Participants recognized the importance of self-care, but they did not seek counseling services for themselves after the school shooting. This study did add to the empirical body by reaffirming these concerns; however, the study did not focus on school social workers or school social work preparation.

Two additional pieces of pertinent literature involved in the targeted gun violence in school literature include Daniels et al.'s (2007) case study on a school counselor who experienced an on-site crisis situation and Austin's (2003) narrative on a school counselor's crisis response and recovery experience at Columbine High School. The Daniels et al. (2007) case study focused on the experiences of one school counselor who was on site and responsive to a school hostage situation. Although this did not involve targeted gun violence, it did pertain to shared trauma. Findings highlighted the importance of crisis response training and the connections/relationships with students and colleagues. The participant in this study was a school counselor and not a social worker. Austin's (2003) was a personal narrative that focused on important themes gleaned from interviews with school counselors who responded to Columbine High School tragedy. The importance of relationships was noted in addition to the importance of staff accessing counseling series after such a crisis. Although shared trauma was the focus, the experiences were not based on social work experience or training.

Common Themes in Response to School Gun Violence Research, in Summary

Of the available studies reviewed pertaining to mental health professionals responding to targeted gun violence within the K–12 school setting, several common themes were identified:

- School mental health professionals may assume formal and informal leadership roles outside their normative responsibilities and scope of practice during the crisis response.
- School-based mental health professionals may have inadequate training or preparation to respond to a crisis event.
- Utilization of the "Zones" is a useful concept to describe the impact on clinicians, students, and school community members connecting their degree of exposure and impact of the shooting.
- Providing crisis response services has an emotional impact on the workers, especially if it involves a shared trauma. Despite knowledge of the importance of self-care and experiences of vicarious trauma, most clinicians did not seek formal support/counseling.
- The importance of relationships was highlighted in the crisis response and recovery as critical in healing.
- Changing view of the media and a distrust that grew from inaccurate reporting.
- The need to limit social media to mitigate further traumatization.

Responsibilities of a School Social Worker

Given the increase in gun violence in the United States, in addition to the prevalence of students with trauma histories, it is critical that school-based mental health professionals and, in particular, school social workers, are trained to respond effectively to a traumatic event at their school. The role of the school so cial worker is frequently misunderstood as diagnostic or treatment-focused in nature. The primary focus of school social workers includes the goals of assisting and enhancing academic functioning through behavioral or psychosocial interventions.

These interventions include assessment and counseling to address social emotional concerns which impact learning. The following is the School Social Work Association of America's definition of the school social work role:

> School social workers bring unique knowledge and skills to the school system and the student services team. School Social Workers are trained mental health professionals who can assist with mental health concerns, behavioral concerns, positive behavioral support, academic, and classroom support, consultation with teachers, parents, and administrators as well as provide individual and group counseling/therapy. School social workers are instrumental in furthering the mission of the schools that is to provide a setting for teaching, learning, and for the attainment of competence and confidence. School social workers are hired by school districts to enhance the district's ability to meet its academic mission, especially where home, school and community collaboration is the key to achieving student success. (SSWAA, 2020, retrieved from https://www.sswaa.org/school-social-work)

The National Association of Social Workers (NASW) also set forth practice standards for school social workers that primarily reflect the importance of aligning practice with the social work values and code of ethics. These standards also note that in addition to micro and mezzo interventions school social workers are trained to assume macro leadership responsibilities and the ability to collaborate with school administration.

Both the NASW and SSWAA describe the school social work role as "complicated" and "specialized"; however, the descriptions of school social work responsibilities are also expansive and broad. Neither specifies that school social workers be trained in crisis response; however,

the lack of specificity in the standards and the noting of the broad range of their social work skills would not preclude them from delivering crisis response services. The extensive nature of social workers' skill base has allowed their role to be fluid in many school districts and social workers are often called upon during trauma and school crises to serve in leadership and supportive capacities (Fein, 2001; Fein & Isaacson, 2009).

School Social Work MSW Preparation and Certification

Given the breadth of responsibilities, it would be reasonable to assume that there are uniform national standards and requirements for school social workers; however, the SSWAA and NASW standards are merely guidelines. In 2021, SSWAA launched a "National Certification" for school social workers; however, the certification is voluntary. Mumm and Bye (2011) conducted a study to evaluate the prevalence of school social work specific training in social work schools around the country and the lack of uniform requirements by state. Their study, a review of all 195 accredited MSW programs in the US, revealed a relationship between schools that offered school social work specific course/concentrations and state certification requirements. Essentially those states with more intensive certification requirements also had MSW programs that offered school specific training within their curriculum. In their literature review they reported the following trends nationwide as of April 2009 regarding school social work certification: 10 states did not require any specific degree or training to be a school social worker, 13 states required a BSW, and 27 states required a Master's Degree, but not all specified in social work. A few states that required a school social worker have a MSW also had other training requirements including a school-based field practicum experience and school social work specific classes. Of the MSW programs in the United States, their study revealed that 42

schools of social work had a specialization/concentration in school social work and 45 additional schools offered a single course/class in school social work, but no concentration or training.

In addition to the lack of uniformity or national certification for school social workers, the Mumm and Bye (2011) study expressed concern regarding the lack of research and literature on school social work certification in general. One of the few articles they cite on school social work certification focused on the correlation between school social worker confidence and curriculum. Slovak, Joseph, and Broussard (2006) studied school social workers' confidence working with topics such as tracking, sexual behavior issues, and school violence. They randomly surveyed 1,400 social workers identified as school social workers through the NASW with a mail questionnaire regarding their school social work specific training. The questionnaire focused on general school social work practice as well as specific social work issues including sexual behavior issues and school violence. Respondents who indicated a school social work specific training experience had an increased sense of their ability to manage school violence and sexual behavior issues within their school setting. Limitations of this study included a low response rate (31%), a sample not necessarily reflective of school social workers nationwide as they had to be affiliated with the NASW, and 85% of the respondents were Caucasian. Also of concern, their definition of school violence was limited and there was no mention of trauma caused by violence in their study. The authors did reinforce the need for further research in this area as well as revisions to the NASW (2012) School Social Work Standards to call for school social workers to have specialized knowledge about their role.

Berger and Samuel (2019) conducted a qualitative study to examine the experience of school mental health professionals in Australia with regard to student trauma support. Semi-structured interviews of 13 school mental health workers revealed several common concerns

including burnout, secondary traumatic stress, a need for additional training, and external supervision. Limitations of this study included no common definition of trauma or trauma-informed practices; however, the authors indicated the lack of a specific definition of trauma allowed greater latitude of participant responses. Another noted limitation was the varied education levels of the participants. The results of this study reinforce the importance of trauma training in addition to the prevalence of secondary traumatic stress and burnout among school mental health professionals. This study did not specifically focus on school social workers nor did it examine the impact of gun related school violence.

Although some MSW programs provide school social work specific coursework as well as general trauma coursework, curriculums do not provide school social work students with specific trauma-informed school social work training with both micro and macro interventions. The University of Southern California Suzanne Dworak-Peck School of Social Work developed the School Social Work Field Training (SSWFT) program in 2020 which includes school social work specific trauma training; however, the training is voluntary and is offered to only students matriculating in their MSW@USC Virtual Academic Center. USC SDP School of Social Work is also reportedly developing a post MSW school social work certification that includes Psychological First Aid (PFA) and Cognitive Behavioral Intervention for Trauma in Schools (CBITS) training.

Traditional school social work courses typically include School Policy and Practice, Behavior Management, Special Populations, School Administrative Policy, Social Work Practice with Children and Adolescents, Interventions with Families and Groups, Substance Abuse, and Education Policy, Special Education and Practice in Schools (Mumm & Bye, 2011). Given the prevalence of both accumulative and acute trauma within the school setting and literature

indicating a lack of training regarding trauma and crisis intervention, trauma-specific school social work training, whether delivered through a MSW curriculum or in post MSW school social work certification, may be beneficial to prepare our future school social workers.

Research Questions

This study seeks to fill an expressed gap in the literature. Specifically, do school social workers who work at schools that have experienced targeted gun violence or social workers hired/contracted by schools in the aftermath of gun violence, feel prepared by their MSW education and training to provide crisis intervention and trauma recovery support to students, staff, and families? What is the professional and personal impact of providing this support? What did school social workers learn about their social work practice and what are the implications for advancing social work education?

CHAPTER THREE

Crisis Response and Recovery: Risks, Models, and Interventions

Targeted gun violence in schools research and literature that focused on the experiences and impact on mental health professionals included reference to both the emotional impact and the specific models of crisis interventions used in these responses (Austin, 2003; Fein, 2001; Fein & Isaacson, 2009; Hagman, 2017; Day et al., 2017; Brown, 2019). In order to provide context for greater understanding of those findings and the findings of this study, an overview of the various models of interventions are offered.

Training and Preparation for Crisis Response and Recovery

A theme identified within the literature on targeted gun violence within schools was the concern that responding mental health professionals were not adequately prepared or trained to provide crisis response and trauma support. The literature highlighted concern about lack of preparation and training to provide crisis response among school-based counselors/mental health professionals; however, it did not specifically focus on the social work profession. This study explores specifically whether school social workers felt prepared by their education or specific training to provide crisis responsive and recovery interventions. In order to fully comprehend the findings of this study, an overview of the stages of a crisis event as well as various crisis response models and interventions is provided.

Stages of a Crisis

Many of the models and the specific interventions are tailored to the type of crisis, the setting in which it occurred, and the stage of the crisis or response. Valent's (2000) five different phases of crisis events will be utilized to explain the specific interventions most appropriate and the stage of the school crisis in which they are commonly implemented.

1. Preimpact (Prior to the shooting)
2. Impact (When the shooting occurs)
3. Recoil (Immediate aftermath of shooting)
4. Postimpact (Days to weeks after the shooting)
5. Recovery and Reconstruction (Months or years after the shooting)

Valent's phases of crisis events was specifically selected for this study as it has been utilized in multiple publications that are specific to school-related crisis response including in the article, *An Integrated Model of School Crisis Preparedness and Intervention*, which highlighted the need for an integrated school specific crisis response model (Jimerson et al., 2005).

Figure 1: Responsibilities of School Mental Health Professionals During a Crisis Event

Figure 1 *School crisis interventions during the different phases of a crisis event*

Pre-Impact *The period before crisis*	*Impact* *The period during crisis*	*Recoil* *Immediately after crisis*	*Post-Impact* *Days to weeks after crisis*	*Recovery/Reconstruction* *Months or years after crisis*
Crisis preparedness • Crisis education • Crisis drills • Crisis planning	*Immediate prevention* • Protect from harm and danger	• Minimize crisis exposure • Ensure actual and perceived safety		
Crisis planning • Establish an inter-agency task force • Establish a school crisis response team • Develop a directory of resources • Establish funds • Establish guidelines for identifying high-risk populations • Specify response facilities • Identify appropriate lodging and shelter • Establish a communication system • Design materials to identify crisis responders • Develop an information decimation system • Develop a plan for dealing with deaths • Plan for medical assistance		*Medical interventions* • First aid • Isolate medical triage	• Ensure treatment of pre-existing conditions	
		Support systems • Reunite with/locate caregivers and loved ones	• Reunite with friends and teachers • Return to school	
		Psychological interventions • Psychological first aid	• Psychological first aid • Group crisis debriefings • Psychotherapy Crisis prevention/ preparedness	• Crisis prevention/ preparedness • Anniversary reaction support Psychotherapy
		Psychological education • Psycho-education groups • Caregiver trainings Informational flyers	• Psycho-education groups • Caregiver trainings Informational flyers	• Anniversary preparedness • Caregiver training Informational flyer
		Risk screening and referral • Initial screening	• Individual screening • Referral procedures • School wide screening	• Individual screening
			Rituals and memorials • Ritual participation • Memorial development	• Ritual participation • Memorial implementation

Source: modified from Brock and Jimerson (2004b).

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Jimerson et al.: School Crisis Preparedness and Intervention

Source: Brock and Jimerson (2004b) as cited in Jimerson et al. (2005)

Although these stages of crisis will be referenced during this study's findings, it should be noted that two additional stage models are utilized in literature including the US Department

of Education (2013, 2019) five mission phases of a crisis which include: (1) Prevention, (2) Protection, (3) Mitigation, (4), Response, and (5) Recovery as well as SAMHSA's (2015) three stage model of acute/immediate, intermediate, and long-term.

Crisis Response Models

There are multiple crisis intervention models available for schools to consider when developing a school crisis team including the NOVA model and the school specific model, PREPaRE; however, there is a significant lack of empirical data on the effectiveness of these interventions in school. Sokol et al. (2021), in *Crisis Interventions in Schools: A Systematic Review*, noted this lack of research of efficacy indicating that even PREPaRE, one of the most popular school-based models, had empirical evidence around only the training components and not its efficacy of implementation. An overview of the two most prominent models referenced in school targeted gun violence literature is included for contextual purposes to support this study's findings.

The National Organization for Victim Assistance Model (NOVA):

Crepeau-Hobson et al. (2012) in their article "A Coordinated Mental Health Crisis Response: Lessons Learned from Three Colorado School Shootings" indicated for the three Colorado targeted shootings the NOVA Model (Young, 1998) and PREPaRE model of psychoeducational groups (Brock et al., 2009) was utilized to both triage and provide long-term support to the school community. The NOVA Model (Young, 2018) has proposed the completion of three tasks as a way to reestablish functioning. The tasks include (1) safety and security, (2) ventilation and validation, and (3) empathy and empowerment. Crepeau-Hobson et al. (2012) have offered a fourth task, empathy and empowerment, based off their own crisis response experience.

The focus of the first task, safety and security, is to reunify/reconnect with families and provide a safe space for reconnection. The primary function of the second task, ventilation and validation, is to allow individuals the opportunity to share their stories in an affirming space. The third task, prediction and preparation, is primarily for when responders provide information about potential trauma responses and assist with community linkage. The fourth task, empathy and empowerment that was developed by Crepeau-Hobson et al. (2012), highlights the importance of understanding the nonlinear aspects of trauma response and the focus on assisting individuals with self-efficacy and self-worth.

Although this model has been used in schools after targeted gun violence, it is not a school specific crisis intervention model nor it is clear whether social workers participated in the development of this model. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2015), in *Disaster Technical Assistance Center Supplemental Research Bulletin: Disaster Behavioral Health Interventions Inventory*, did not categorize the NOVA Model as a school-based intervention model.

The PREPaRE Model

The PREPaRE Model (Brock et al., 2009), a school-specific crisis intervention model, stands for Prevent, Reaffirm, Evaluate, Provide and Respond, and Examine. It highlights the steps a school crisis team should follow and implement during the five stages of a crisis event. This model was developed by school psychologist scholars to meet the needs of a school-specific crisis intervention model and was supported by the National Association of School Psychologists (NASP). It is unclear whether school social workers contributed or provided information for this model development.

Brock et al. (2009) has asserted that the school setting is unique in its crisis response needs; therefore, it requires its own model. In addition, the authors of PREPaRE stated that school mental health professionals are those most prepared to address psychological distress within schools and are essential members of school crises teams. The developers outlined the following hierarchal responsibilities after a school crisis:

> P—Prevent and prepare for crises
> R—Reaffirm physical health & welfare, and perceptions of safety & security
> E—Evaluate psychological trauma risk
> P—Provide interventions
> a—and
> R—Respond to mental health needs
> E—Examine the effectiveness of crisis preparedness

Source: Brock et al. (2016)

This model provides school mental health professionals information on both prevention and interventions of crisis response. The curriculum guides crisis response professionals on the specific micro, mezzo, and macro interventions needed for each stage of the crisis. The PREPaRE Model incorporates guidance from the US Department of Education (2013, 2019), Homeland Security (2008, 2011), and FEMA (2011) into their recommendations. The model uses the Readiness and Emergency Management for School Technical Assistance Center (2013) five stages of crisis response: (1) Prevention (2) Protection (3) Mitigation (4) Response and (5) Recovery. Although literature on PREPaRE has detailed the reason it was developed and the theoretical basis upon which it was developed, the details of the curriculum are only provided through online, fee-based NASP workshops.

Specific Crisis Interventions and Trauma Interventions for Schools

SAMHSA (2015) has detailed the specific crisis and recovery interventions and categorizes the interventions by recommended stage of crisis and practice setting in *Disaster*

Technical Assistance Center Supplemental Research Bulletin: Disaster Behavioral Health Interventions Inventory. This resource labels the phases of crisis intervention as: early/immediate, intermediate, and long-term. The goals of early/immediate and intermediate interventions are noted as mitigating the development of significant psychological impact and supporting the recovery process for both individuals and the community. SAMHSA (2015) has defined early or immediate as within hours to four weeks after the crisis event and the intermediate phase is considered four months to the one-year mark of the event. Long-term interventions are typically implemented as a result of the psychological distress from the trauma event contributing to impairment in functioning. Early/immediate interventions are focused on early mitigation of psychological distress and stabilization. Intermediate interventions can focus on anxiety management, cognitive restructuring, and supporting coping skills. Long-term interventions are more focused for treatment of trauma conditions such as Post-Traumatic Stress Disorder (PTSD). Interventions selected for inclusion in this literature review are school setting specific and mentioned by study participants during the data collection.

Psychological First Aid - Acute/Immediate

One of the most utilized evidenced informed interventions in both the early/immediate and intermediate phases is Psychological First Aid (PFA). Although there has been limited literature on the efficacy of PFA in the immediate aftermath of a crisis, specifically a mass crisis involving school targeted gun violence, there is universal agreement anecdotally that PFA can assist with stabilization and connection. Fox et al. (2012) conducted a systematic review which concluded, PFA "is widely supported by available objective observations of measurement of effectiveness and expert opinion and best fits the category of 'evidenced informed' but without proof of its effectiveness" (p. 251). PFA as an intervention for acute stress reaction can be traced

back to military use during WWII (JAMA, 1954, 1957). Its use in the aftermath of traumatic events has been supported by the American Red Cross (ARC), National Center for Post-Traumatic Stress Disorder, SAMHSA, and National Child Traumatic Stress Network (NCTSN). PFA can be administered by both mental health professional and non-mental health volunteers trained in the intervention. The aim of PFA is to mitigate acute distress, provide support to enhance adaption after a trauma event, and assist with connection to resources (Ruzek et al., 2007). There are eight core helping actions or components involved in the intervention: (1) contact and engagement, (2) safety and comfort, (3) stabilization, (4) information gathering, (5) practical assistance, (6) connection with social supports, (7) information on coping support, and (8) linkage with collaborative services (NCTSN, 2012).

There are many adaptions of PFA based on practice setting and developmental age. The two adaptions that are most applicable to this study are Psychological First Aid for Schools (PFA-S) and Psychological First Aid- Listen, Protect, Connect – Model & Teach (PFA-LPC). Brymer et al. (2012) developed the *Psychological first aid for schools: Field operations guide* for the NCTSN, which includes helpful school-specific setting information to assist with implementation of the PFA Eight Core Actions within the school system. NCTSN offers online training for PFA and is primarily geared toward mental health professionals (Jaycox et al., 2014).

Schreiber, Gurwitch, and Wong (2006) developed the PFA-LPC intervention to be integrated within the school setting and with consideration of the developmental needs of students around safety and communication. This five-step crisis intervention adaption of PFA was designed to be used by any of the school staff with the goal of stabilization so students can re-engage in learning. PFA-LPC provides trauma-sensitive communication guidelines as well as

a built-in triage tool that assists with determination of the need for immediate or ongoing psychiatric or psychosocial support. The PFA-LPC (Schreiber et al., 2006) five steps include:

(1) Listen – allow students the opportunity to ventilate their feelings or share their experiences in a group or individual setting.

(2) Protect – sharing of information with students in attempt to restore a sense of physical and emotional safety. Encouragement to avoid retraumatization through rewatching the trauma or news about the trauma through social media or news.

(3) Connect – assist students with connection or reconnection to social supports to prevent isolation after the trauma.

(4) Model Calm & Optimistic Behavior – self-awareness to model calm behavior express hope for the future as students pay attention to both verbal and nonverbal behavior of adults during crisis.

(5) Teach – provide psychoeducation to normalize potential reactions to the trauma.

Ramirez et al. (2013) conducted a pilot study on the efficacy of PFA-LPC with middle school students exposed to life stressors. Findings from this eight-week quasi-experimental study revealed a reduction in both depressive and PTSD symptoms as well as reported increase in social support and connectedness. Limitations include lack of a control group and delayed implementation after trauma event due to logistical factors. PFA-LPC training is available either online or in person through the Treatment and Services Adaptation Center (TSA).

Cognitive Behavioral Interventions for Trauma in Schools (CBITS) – Intermediate

SAMHSA (2015) listed Cognitive Behavioral Intervention for Trauma in Schools (CBITS) as an intervention for the intermediate phase of the response. CBITS is an evidenced-

based intervention that uses both individual and group modalities to decrease the symptoms of depression, PTSD, and psychosocial distress (Jaycox et al., 2006a; Jaycox et al., 2010; Jaycox et al., 2014). CBITS includes 10 group sessions, 1–3 individual sessions, 2 pychoeducational meetings for parents, and 1 education focused meeting for teachers. The aims of CBITS are not only to reduce PTSD and depressive symptoms, but to enhance the resiliency factors of connection and support to improve adaptation (Jaycox et el., 2012). The curriculum contains elements of psychoeducation, cognitive restructuring, relaxation, and problem solving. There is significant empirical data dating back to the first research study (Kataoka et al., 2003) to support the use of CBITS in school to reduce the symptoms of depression and PTSD (Jaycox et al., 2012; Kataoka et al., 2011; Cohen et al., 2009). Online and in-person training is available through cbitsprogram.org.

Bounce Back - Intermediate

Bounce Back is an adaptation of CBITS for students aged 5–11 years old. Similar to CBITS it includes elements of cognitive restructuring, psychoeducation, relaxation, and problem solving in addition to a trauma narrative, a component of Trauma Focused CBT (Langley et al., 2015). Bounce Back includes the same amount of individual and groups sessions as CBITS; however, there is more engagement with parents through additional parent meetings. A 2015 study conducted with 74 elementary schools revealed an improvement in depressive, anxiety, and PTSD symptoms in those who received the Bounce Back Intervention. Limitations included a small sample size and a lack of a comparison treatment group. Online training for Bounce Back can be found online at bouncebackprogram.org.

Mind/Body Therapies - Intermediate

SAMHSA (2015) mentioned mindfulness-based interventions, such as meditation and yoga, as promising tools for stress reduction and management of the physiological symptoms of trauma; however, there is not enough empirical evidence to justify their use as a stand-alone intervention in crisis response. Mindfulness as a component of an intervention such as Mindfulness Based Stress Reduction and Mindfulness Based Cognitive Therapy (Kabat-Zinn, 1992) does have some empirical evidence for use; however, mindfulness is only a component of these interventions. Despite the lack of empirical support, many clinicians use mindfulness strategies for grounding or relaxation purposes.

Trauma-Focused Cognitive Behavioral Therapy – Long Term

SAMHSA (2015) has categorized Trauma Focused- Cognitive Behavioral Therapy (TF-CBT) within the long-term phase of crisis response and recovery; however, it acknowledges the uniqueness of every individual's response and the possibility that this intervention can be implemented sooner. Long-term intervention is often needed for those individuals who experience lasting psychological distress with mental health symptoms such as a diagnosis of PTSD. It is an evidenced-based intervention designed specifically for children and adolescents to treat symptoms of PTSD. Studies have indicated that TF-CBT can also effectively treat the affective and behavioral symptoms associated with trauma such as depression, anxiety, and disruptive behaviors (Cohen et al., 2012). Similar to CBITS and Bounce Back, there is a parental/caregiver component to the intervention. TF-CBT uses the acronym "PRACTICE" to outline the core components of the intervention: **P**sychoeducation & parenting, **R**elaxation, **A**ffective Expression & modulation, **C**ognitive coping, **T**rauma narrative & processing, **I**nVivo exposure, **C**onjoint parent-child sessions, and **E**nhancing safety & future development (Cohen et al., 2006; Cohen et al., 2012).

There is significant research to support this including randomized control studies, the gold star standard of research design. Research has also shown its efficacy in symptoms after traumatic grief, and after acute trauma such as after Hurricane Katrina (Cohen et al., 2009; Jaycox et al., 2010) and for traumatic grief reactions (Cohen et al., 2006; 2012). Although the developers of this intervention are not social workers, social workers have been active in the research around its efficacy in school-based settings and after disasters. TF-CBT is not specifically a school-based intervention, but it has been utilized in larger school districts that have counseling centers or school-based clinics.

Personal and Professional Impact of Crisis Response

In addition to the concern about lack of preparation for school mental health professionals, review of relevant literature also noted a concern on the personal and professional impact on the crisis responders. The aforementioned crisis response frameworks focus on the supports provided to individuals and the community while only briefly discussing the protective measures for responding school mental health professionals. One of the common themes identified in the school gun-related research was the prevalence of Secondary Traumatic Stress (STS) and Vicarious Trauma (VT) among the responding mental health professionals. These conditions in particular, were identified in those responders that also experienced the shared trauma of the violence, either by being a member of the school or the larger geographic community (Brown, 2019; Day et al., 2017; Crepeau-Hobson et al., 2008; Fein et al., 2008). Review of literature revealed that mental health professionals in general are at risk to develop symptoms of STS and VT due to the nature of the work (Figley, 1982; Newell et al., 2016; Wagaman et al., 2015). This practice phenomenon in clinical work has been coined as the "cost of caring" (Figley, 1982). Newell et al. (2016) in their article, "Clinician Responses to Client

Traumas: A Chronological Review of Constructs and Terminology", asserted that "clinical providers can absorb some measure of the emotional pain their clients endure while listening to individuals, families, groups, or even entire communities describe their experiences of suffering (Newell et al., 2016, p. 306). The authors noted the terms STS and VT, in addition to the terms compassion fatigue and secondary victimization, are often used interchangeably both in literature and in practice to describe this condition. For the purposes of this study, both STS and VT were offered to participants in order to capture the expansive nature of these terms.

Being emotionally impacted by clinical work is not a recent phenomenon and it can be traced back to the idea of transference and countertransference in psychoanalytic theory (Newell et al., 2016; Freud, 1923). In the 1990s, the term Vicarious Traumatization was introduced to describe the professional and personal impact of being exposed indirectly through empathetic engagement to clients' emotional responses to trauma (Newell et al. 2016; McCann & Pearlman, 1990; Pearlman & MacIan, 1995). By 1995, this term was shortened to "Vicarious Trauma" (VT) (Perlman & Saakvitne, 1995) which is the common terminology used today. VT can include both cognitive and behavioral changes with respect to the clinician's sense of self as well as their world views around spirituality, trust, and safety (Newell et al., 2016). Signs and symptoms of VT can include avoidance, hyper/hypo arousal, sleep disturbance, intrusive thoughts, interpersonal difficulties, behavioral changes, and mood dysregulation (Perlman & Saakvitne, 1995).

The symptoms of VT mirror some of the symptoms captured by the Diagnostic and Statistical Manual of Mental Disorders (DSM V) of Post-Traumatic Stress Disorder (PTSD) including hypervigilance, avoidance, and thought rumination (Ursano et al., 2009). Recognizing these commonalities, Charles Figley introduced the term Secondary Traumatic Stress in the mid-

1990s to describe the secondary effects of trauma on clinicians as a result of their interventions with clients (Figley, 1995; Stamm & Figley, 1995). He defined Secondary Traumatic Stress as "natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other (client) and the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p. 7). Symptoms of STS can include: hypervigilance, avoidance, hopelessness, anger, irritability, cynicism, sleep/appetite disturbance, sadness, fear, increase anxiety, and physical ailments (Bride, 2007; Siegfried, 2008; Newell & MacNeil, 2010). Similar to VT, it was suggested that STS is a result of empathetic aspect of engagement with a traumatized client and exposure to the details of that trauma. Given the traumatic aspect of crisis response work especially after targeted gun violence in schools, it is not surprising then that responding mental health clinicians experience significant risk for the development of STS/VT symptoms.

Risk Factors and Protective Factors

Given the nature of clinical work, especially crisis intervention, responding mental health professionals are exposed directly or indirectly to the trauma of clients and are at high risk for developing symptoms of VT and STS (Figley, 1995; Bride, 2007; Wagaman et al., 2015). Literature around risk factors has noted in addition to type and length of exposure, clinicians who had a previous trauma history or history of anxiety were more vulnerable to experience traumatization through the work (Figley, 1995; Huggard, 2003; Hydon, 2016). Additional risk factors proposed included lack of job satisfaction, difficulty with boundary management, and being overly empathetic or caring (Figley, 1982; McCann & Pearlman, 1990; Figley, 1995; Pearlman & MacIan, 1995; Newell et al., 2014). Protective factors noted in the literature included engagement in self-care activities, maintaining physical health (sleep, nutrition,

exercise), access to support through personal relationships, collegial support, access to supervision, setting boundaries, job satisfaction, and empathy (Maslach, 2003; Lakey & Cohen, 2000; O'Halloran & O'Hallaran, 2001; Zimmering et al., 2003; Wagaman et al., 2015). Review of literature on VT and STS revealed that empathetic engagement was noted as both a risk factor and a protective factor.

Empathy: Risk Factor or Protective Factor

VT and STS both identify the empathetic aspect of clinical work with a traumatized client as a potential precipitant to development of these conditions. According to Wagaman, Geiger, Schockley, and Segal (2015) in their article "The Role of Empathy in Burnout, Compassion Satisfaction, and Secondary Traumatic Stress Among Social Workers", "Empathy is the ability to understand what other people are feeling and thinking and is an essential skill in facilitating social agreement and successfully navigating personal relationships" (p. 203). One of the social work educational competencies is the ability to use empathy, reflection, and interpersonal skills to effectively engage diverse clients and constituencies" (CSWE, 2015, p. 9) Empathy is one of the building blocks of engagement in social work, a practice that extolls the importance of the relational aspect of the therapeutic alliance. Client-centered, strengths-based humanistic approaches which emphasize empathy are common in the practice of social work and empathy is considered critical for positive treatment outcomes (Elliott et al., 2011; Gibbons, 2011; Neuman et al., 2009; Wagaman et al., 2015). Relational Cultural Theory (RCT), a therapeutic framework developed by clinicians Judith Jordan, Jean Baker Miller, Irene Stiver, and Janet Surrey in the 1970s, and one of the theoretical frameworks for this study, states that empathy is critical to the development of growth fostering relationships which is not only essential to the therapeutic relationship, but relationships in general (Miller, 1986; Jordan, 2018).

RCT also uses cognitive neuroscience to explain how mutual empathy is an inherent part of client work, it is human instinct to strive for authentic relationships, and there is a neurobiological impact from this connection (Banks, 2015). Wagaman et al. (2015) explored the four components of empathy as conceptualized by cognitive neuroscience including (1) affective response, (2) self-other awareness, (3) perspective taking, and (4) emotional regulation in their study of 173 social workers in practice and social work education. Findings revealed that empathy can be a learned skill that can be used to buffer the social worker from the negative impact of ST and VT. The authors extolled the importance of all four components of empathy being accessed and functioning in order for it to be protective in nature. "Empathy can help social workers maintain professional boundaries by training them to be mindful of self-other awareness and emotion regulation…." (Wagaman et al., 2015, p. 206). Limitations of the study included a racially- and gender- homogenous sample and lack of information on participant environmental risk factors and trauma exposure level.

Newell et al. (2016), in the article "Clinician Responses to Client Traumas: A Chronological Review of Constructs and Terminology", also noticed the potential protective factor of empathy and the shift in the literature to focus on its contribution to Posttraumatic Growth and Compassion Satisfaction. The authors discussed that empathy and compassion are inherent aspects of the helping profession work; however, empathy within the work can be viewed as a source of stress, but also as a potential source of strength (Radey & Figley, 2007; Stamm, 1998). Newell et al. (2016) stated, "it has been suggested that learning to regulate empathy as one interacts with clients and their experiences can actually promote the growth of practice wisdom" (p. 310).

CHAPTER FOUR

Theoretical and Informed Frameworks

This qualitative grounded theory study will examine the experiences of school social workers in districts impacted by targeted gun violence through two theoretical lens: Ecological Systems Theory and Relational Cultural Theory. These theoretical frameworks were selected to capture the macro-, mezzo-, and micro-level responsibilities of school social workers in addition to the importance of relational interactions within the work as it pertains to individuals and systems impacted by trauma.

Ecological Systems Theory

School districts are the quintessential example of a large system with multiple parts and functions that impact various stakeholders including students, families, faculty/staff, and the larger community in which the district is located. School social workers interact with and within these various systems to provide social-emotional intervention to assist students with optimal learning. Ecosystems Theory was developed by Uri Bronfenbrenner (1979) and posits that human development does not occur within an isolated vacuum. Rather, the environment surrounding the individual has direct and indirect influence on development. Ecological Systems Theory, or the person-in-environment framework, is one of the foundational theories within the social work profession as it recognizes the impact interactions within the environment can have on the developing individual as well as the impact the individual can have on the environment (Rosa & Tudge, 2013). This theory was selected as one of the frameworks for this study because

school social workers are able to support students and intervene within the different layers of the school and community.

Bronfenbrenner proposed that the environment could be characterized in different systems that interact with the individual as well as with each other – each influencing each other as well as the individual's development. He proposed the following levels of influence which are nested within each other: microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Brofenbrenner, 1979, Rosa & Tudge, 2013; Neal & Neal, 2013). For the sake of this dissertation we are defining the microsystem as the influence of the most immediate or proximal setting such as the social worker's home or the school; the mesosystem is the relational interaction between the social worker and other microsystems such as the social worker interacting with students or talking to a teacher; the social worker does not interact directly with the third layer, the exosystem, but it has indirect influence on the social worker through domains such as educational policy; and the macrosystem is the outermost layer that encompasses broader influence on both the social worker as well as the layers such as societal values, customs, laws and expectations (Bronfenbrenner, 1979, 1994; Rosa & Tudge; Neal & Neal, 2013). The chronosystem does not refer to one of the proposed nested layers rather it is a marker of time in development such as births, deaths, divorce, or illness as examples (Bronfenbrenner, 1979).

Trauma can impact how all of the systems interact with each other. In mass targeted school shootings, students and their microsystems are impacted – the school, their homes, and their families. Trauma also impacts and often impairs functioning within the mesosystems or how the microsystems interact and relate to each other. The exosystem is often altered or influenced by the trauma, for example through changes in educational policy or in actions of the school crisis teams. The impact of such violence does not leave the larger communities

untouched or the macro system and often there is advocacy for changes at a more expansive level such as gun safety law reform.

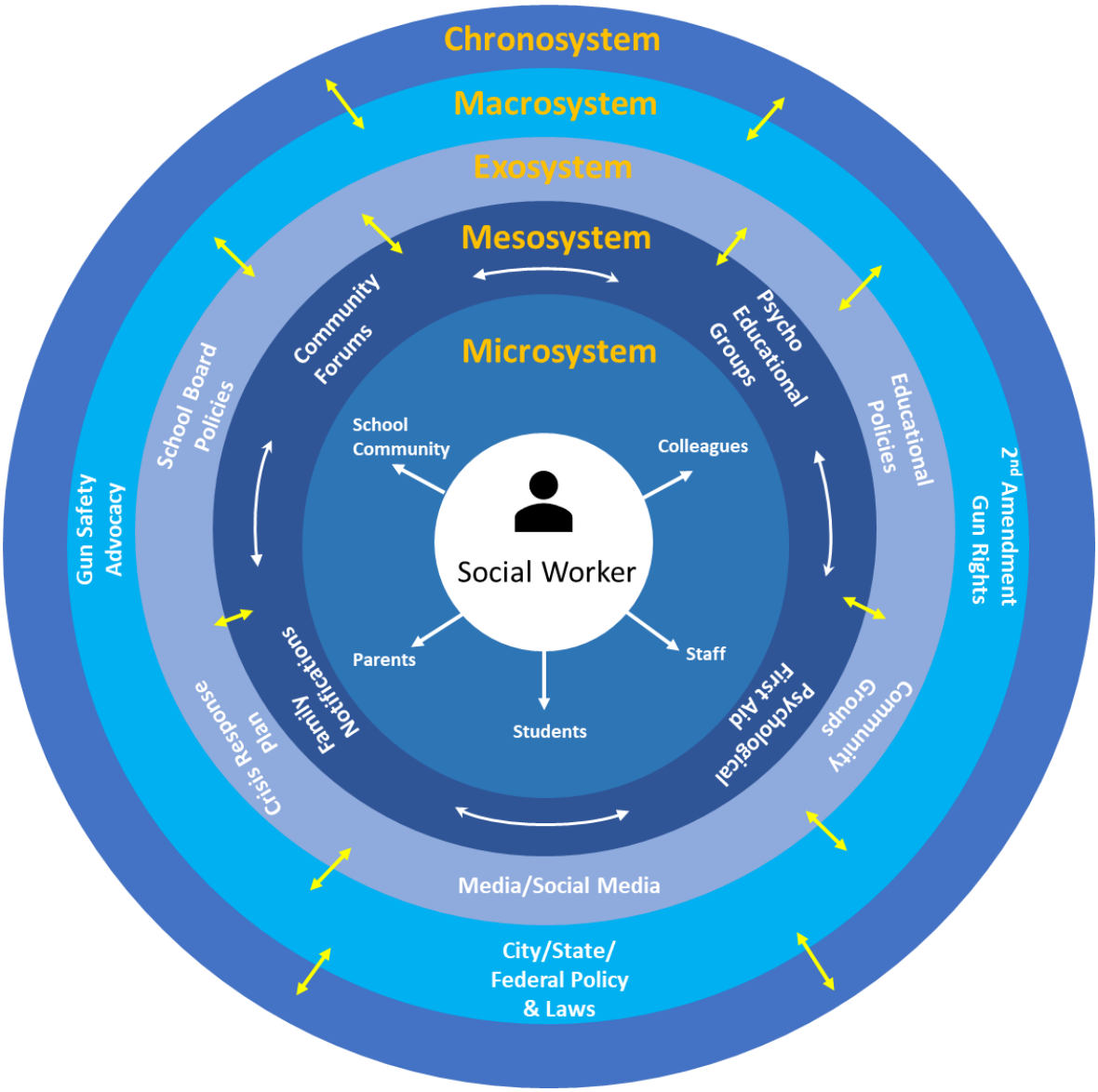
Another relevant aspect of the ecological systems theory to this proposed study is the classification of systems based on scope and intricacy. The use of terminology such as micro-, mezzo-, and macro-levels are common descriptors of targets of social work interactions and interventions. Micro-level interventions refer to work involving individuals or couples; mezzo-level intervention describes work with larger entities such as families or medium size groups; macro-level social work involves larger systems such as organizations or communities. School social workers require the ability to interact and intervene on behalf of the student with each of these systems and the intersections between them. Although school social workers engage in this intervention on a daily basis in the school setting, responding to a school crisis such as targeted gun violence amplifies responsibilities across systems levels.

School social workers and other counselors are often tasked with additional responsibilities outside of their normative responsibilities because the school system is experiencing its own trauma from the violence (Fein, 2001; Fein et al., 2008). Micro-focused interventions from a school social worker in the aftermath may include psychological first aid to students, staff, and parents; mezzo-focused interventions could include psychoeducation to parents and community or communication with the media; and macro interventions could include involvement in communication and organization of a systems-wide crisis response and recovery plan.

Ecological systems theory was one of the selected frameworks for this study due to the expansive nature of trauma. A tragedy such as a school shooting impacts not only those who were hurt or witnessed it, but the families of the students and staff, the wider school community

as well as the geographic community. It is a part of our nation's collective experience and international reputation. Gun violence in schools leaves the communities and all the systems within the community impacted. School social workers, typically trained in ecological systems theory, are accustomed to intervening with the multiple influences of person-in environment.

Figure 2: Ecological Systems Impacting the School Social Work During Crisis Response and Recovery



Adapted from Bronfenbrenner (1994)

Relational Cultural Theory

In order to effectively navigate the systems within the school district and within the lives of students, social workers often use a relational approach in their work; therefore, for the purposes of this study a Relational Cultural Theory (RCT) lens will be utilized to inform the data collection and analysis. RCT is a theoretical framework developed in the late 1970s by clinicians Judith Jordan, Jean Baker Miller, Irene Stiver, and Janet Surrey. This framework was initially born from the second wave feminism and draws upon the works of interpersonal therapy, objection relations theory, and attachment theory (Jordan, 2018; Banks, 2011, 2015; Bowlby, 1958, 1980, 1988; Gilligan et al., 1993; Goldstein, 2001). One of the foundational tenets of RCT is the importance of connection. Western society purports the idea that separation and individuation is normative and interdependence is abnormal; however, RCT proposes that it is human nature to move toward connection and that disconnection contributes to distress and dysfunction (Jordan, 2018). RCT also highlights the relational neuroscience that provides neurobiological evidence to support the power of connection (Banks, 2015). As a framework RCT centers the importance of intersectionality as well as the influence of power and systems of oppression within an individual's life. It is a framework that encompasses the micro and macro aspect of therapeutic work. There is not only disconnection at an individual level, but distress and suffering that can occur due to societal disconnection caused by racism and marginalization (Walker, 1999). RCT encompasses the concepts that are critical within the work of a school social worker.

Relationships in RCT

RCT states that connection occurs in relationships that have the qualities of respect and bidirectionality (Walker et al., 2004). These are considered "growth-fostering" relationships. Jordan (2018) asserts that growth-fostering relationships are critical in the healthy development of human beings. In RCT, growth-fostering relationships are defined as ones which promote mutual development and foster a (1) sense of clarity, (2) zest, (3) self-esteem, (4) empowerment, and (5) a desire for more connections (Miller, 1986; Jordan, 2018). Miller (1986) has asserted that these "Five Good Things" are a critical component of growth-fostering relationships. Jordan (2018) also stated that mutual empathy and authenticity are necessary in any healthy or growth-developing relationship and particularly beneficial in the therapeutic relationship.

Empathy is an important concept not only in RCT, but in the social work profession. One of the core competencies of social work education is to "use empathy, reflection, and interpersonal skills to engage clients" (CSWE, 2015). RCT encourages both authenticity and mutual empathy in relationships. Authenticity in the therapeutic relationship is not indicative of a casual or unprofessional approach with needless self-disclosure, but rather "therapeutic authenticity is based on the development of an understanding of the patient, a caring about the impact of what we share with the patient and careful clinical consideration based on our work, our understanding of what would be therapeutic for the patient" (Jordan, 2001, p. 98). This understanding is developed through mutual empathy and the establishment of a therapeutic alliance. Mutual empathy in RCT refers to a clinician's ability to engage in a reciprocal relationship of respect in which the client recognizes that the clinician is not only listening to their experiences from a position of neutrality, but that their experiences are impactful and significant to the clinician (Walker et al., 2004; Jordan, 2001). The key difference between empathy and mutual empathy is that mutual empathy is bidirectional in order to create the

empathic attunement. Hall et al. (2014) have proposed that one-way empathy can actually be a barrier to an authentic relationship and that clinicians can encourage clients to engage in a mutual exchange through requesting client reactions to the exchange. Mutual empathy is one of the key factors in relational resilience and deeper connection.

The concept of resilience has often been characterized by traditional psychological theories as overcoming adversity, adapting to stress, and pushing through challenges – all focused on the industriousness of the separate self (Jordan, 2018). Within this lens, resilience has often been viewed as a component of an individual's character or personality. Jordan (1992) proposed that resilience be viewed from a relational perspective in which transformation through relationships assists a client's movement from disconnection to connection and ultimately healing. In order to facilitate this transformation, the relationship(s) benefit from the inclusion of supported vulnerability, mutual empathy, awareness, and relational confidence (Jordan, 1992). RCT normalizes disconnections as common through the lifespan, but its proponents propose that chronic disconnection can contribute to the development of distress and impairment in functioning (Banks, 2011). Relational resilience occurs when the client demonstrates the capacity to move back into connection – a capacity that is enhanced through mutual empathy and the authenticity of the therapeutic relationship.

Relational Neuroscience

Banks (2015), in her book *Wired to Connect*, discussed the neuroscience behind the human instinct for connection and relationship specifically the physiological impact of fear, sadness, and anxiety. Disconnection and isolation impact the nervous system and trigger changes in neurochemistry including the levels of adrenaline, cortisol, and oxytocin. Both Banks (2015) and Jordan (2008) have referenced Social Pain Overlap Theory (SPOT) which emerged

from the research of Eisenberger and Liberman (2004) who identified that social pain from disconnection and physical pain travel along the same neural pathway to the brain. In essence, the distress caused by social exclusion, isolation, or disconnection could be equated to the perception of physical pain within the body. In this study, "social pain" was defined as "the distressing experience arising from the perception of actual or potential psychological distance from close others or a social group" (Eisenberger & Liberman, 2004, p. 294). This study in addition to others which substantiated these findings (Krill & Platek, 2009; Onoda et al., 2010) have supported RCT's assertion that isolation and disconnection can be the source of distress and that healing can be facilitated through connection. Banks (2015) also posited the power of positive relationships to heal and reorganize neural pathways of despair and trauma. Historically it was hypothesized that once there is injury to the brain it was permanent; however, research on neuroplasticity has demonstrated the brain's ability to heal, change, and grow despite injury (Banks, 2015; Jordan, 2018; Siegel, 2012).

Mutual empathy is an important concept in RCT and the core foundation of growth-fostering relationships also has neuroscience research that provides insight into its mechanism. The Mirror Neuron System is an involuntary system that helps us make sense of the world around us and understand ourselves from an existential way (Banks, 2015). Mirror Neurons do not equate to empathy; rather, they provide insight into the mechanism by which empathy can occur. Iacoboni (2009) explained how the mirror neuron system assists with intersubjectivity providing a social context into how we perceive others to be feeling. Iacoboni and Dapretto (2006) demonstrated the relationship between increased activity with the Mirror Neuron System and increased social competence and empathy. Essentially, it allows a clinician to understand what a client may be feeling and thinking by imitating them internally or from a neurobiological

level – the ability to resonate with someone (Banks, 2015; Banks, 2020). There is ample data from neuroscience to support the idea that humans are in fact "wired for connection" with each other.

Relational Cultural Theory (RCT) Terminology

In order to connect the tenets of RCT with the work of school social workers' responses to targeted gun violence, the following definitions of the RCT will be used:

Table 1: RCT Concepts and Examples of Utilization in this Study

Concept	**Utilization of Concept in Study**
Mutual Empathy – when a social worker/therapist allows the client relationship to be meaningful and express the reciprocal nature of the relationship through selective and appropriate self-disclosure.	When providing crisis response and ongoing trauma support, school social workers can utilize selective self-disclosure to validate a client's feelings of shock, anger, and sadness.
Authenticity – representing or presenting one's full self in a relationship while being able to respond with empathy to others.	School social workers can navigate their multiple roles within the school district and engage in meaningful genuine relational interactions while providing crisis response and support services.
Connection – relationships which foster respect, bidirectionality, and safety. .	School social workers focus on creating connections with students, staff, and the community to provide crisis intervention, psychoeducation, support, and linkage to community supports.

Disconnection – when individuals disengage or avoid relationships/connection with others.	School social workers can identify when students/clients have disengaged from relationships or the community as a result of the stress/trauma.
Relational Resilience – is an individual's ability to resolve disconnection and reconnect in growth fostering relationships.	Through mutual empathy, authenticity, and evidenced based interventions, school social workers can assist students/teachers etc. to reconnect with community and engage in growth fostering relationships.

Connection and Trauma

Social work is a profession in which the relational aspect of the intervention is traditionally emphasized (Applegate & Shapiro, 2005; Abrams & Shapiro, 2014). Relational characteristics as outlined in RCT are particularly significant when interacting and building relationships with individuals who have experienced trauma such as gun-related school violence. Abrams and Shapiro (2014) have proposed that social work curriculums would better prepare social workers for the field if coursework included the teaching of trauma theory. Herman (1992) indicated the healing of trauma occurs in the context of relationships (Abrams & Shapiro, 2014). Herman discussed the treatment differences within the types of trauma, differentiating between single-exposure acute trauma like targeted gun violence or complex trauma which can occur repeatedly over a period of time such as child abuse. Although statistics point to the prevalence of complex trauma through the study of ACEs, school social workers should be prepared and are often required to provide response to both acute and complex trauma.

Trauma responses can present differently depending on the individual person and the nature of the collective trauma. School social workers responding to a collective trauma such as school gun violence and utilizing a RCT approach recognize the importance of connection through relationships. RCT proposes that isolation and disconnection from others is the source of distress and that healing occurs in growth-fostering connection (Banks, 2015; Jordan, 2018; Jordan, 2001). The power of connection versus disconnection can even be identified in two national traumas: September 11th and the COVID pandemic. After the September 11th tragedy, individuals attended memorials, volunteered their time, and found ways to connect with one another to grieve the lives of 2,977 people lost that day. Conversely, due to COVID restrictions and fear, the ability to connect and mourn the death of almost 650,000 Americans from COVID-19 has been limited, leading to disconnection and a sense of hopelessness. Both events were considered national and collective traumas: one in which individuals sought comfort from one another, and the other in which forced isolation kept us disconnected.

Disconnection After Targeted Gun Violence

RCT posits that connection through growth-fostering relationships is a vehicle for healing trauma especially chronic trauma (Jordan, 1992, 2001, 2018; Banks, 2015). Targeted gun violence in schools is an acute trauma that can impact both the individual and all the levels of systems within the individual's environment. RCT acknowledges that disconnection is a normative experience and that distress can occur when these disconnections are prolonged and not addressed (Jordan, 1992, 2001, 2018). Fear, isolation, and distrust are common responses in the aftermath of school gun violence (Fein, 2001; Hagman, 2017). Parents send their children to school with the expectation they will return at the end of the day. Historically, school was considered a safe environment; however, that illusion has been shattered for many with the

images of students running from the building at Columbine, Sandy Hook, and Marjory Stoneman Douglas. Today's generation of children have attended school in a time when active shooter drills have become as necessary and routine as fire drills. Despite this safety preparation, all the participants in this study mentioned how they were shocked when a shooting occurred in their community. When targeted gun violence occurs a sense of safety and control is lost. Shock and fear can lead to anxiety and isolation – or in RCT terms, "disconnection." Interventions such as Psychological First Aid, which focuses on safety, stabilization, and connection with supports, in the immediate aftermath is critical to mitigating the impact of acute trauma.

School Social Workers and RCT Across Ecological Systems Levels

In the immediate aftermath of school violence, school social workers are often tasked with providing crisis response services to the school community including students, teachers, and parents. After trauma that involves loss of life there can be a sense of shock, anger, and sadness. As previously stated, when that trauma involves community violence, there can be a perceived loss of safety. From a connection perspective, comfort is often sought through growth-fostering relationships in times of fear. From a microsystem perspective, social workers need to use both a sense of awareness and reflexivity in their individual work with others especially if the social worker shares the trauma. Social workers are supporting relational resilience and mutual empowerment through relationships that foster authenticity and mutual empathy with students, faculty, and parents. In targeted gun violence in schools, it often becomes more challenging for social workers to navigate the shared trauma of a mass shooting. Mutual empathy without awareness can contribute to development of Secondary Traumatic Stress (STS) and Vicarious Trauma (Day et al., 2017). During situations of shared trauma, social workers can be "deprived of the clinical distance usually afforded them by having a different set of external experiences

than that of the client" (Tosone et al., 2012, p. 626). Awareness of boundaries and self-care while engaging in empathy often assists with self-regulation of emotion and reduction of the risk for STS (Wagaman et al., 2015; Newall et al., 2016).

From a mesosystem perspective, social workers can also experience relational resilience in their connections with colleagues and supportive relationships within the community. Day et al. (2017) noted in their study that the clinicians at Virginia Tech felt a deeper sense of connection and cohesion in the workplace and in the community in the aftermath of the shooting. There is significant literature on how secure and health attachments can assist with coping (Agaibi & Wilson, 2005; Day et al., 2017). Health and positive attachment would be akin to growth-fostering relationships in RCT. In all of the gun-related school violence studies, the importance of relationships has been noted in the response and recovery efforts (Day et al., 2017; Hagman, 2017; Crepeau-Hobson et al., 2012; Fein et al., 2008).

School social workers can be instrumental in organizing and encouraging connection on a macro level within the school community and the larger community through crisis support, referrals, vigils, memorials, and social advocacy movements. From immediate crisis intervention, to assisting school leadership in development of school-wide responses, to providing support to individual students so they can return to the classroom, school social workers are using the strength of their relationships not only to organize and deliver a coordinated response across all levels of the ecological system, but to foster a sense of relational resilience and mutual empowerment.

CHAPTER FIVE
Methodology

Research Design

This study focuses on social workers who worked within US schools or who were hired/contracted in the immediate aftermath by US schools that experienced targeted gun violence which resulted in multiple injuries and/or death(s). This study used a qualitative frame which allowed an expansive scope as well as provided the opportunity to explore the depth of each participant's unique experience. Also given the sensitivity of the research topic, crisis response to targeted gun violence in schools, qualitative research allowed for the time, space, and relational connection needed for participants to share trauma related experiences. The importance of relationship and connection is a theme highlighted in the findings and one of the methodological approaches. Qualitative research may utilize an existing framework or theory as an initial orienting lens in which to design and interpret a study; it encourages an open and flexible stance that allows for spontaneity and deep exploration. Qualitative researchers use existing theories and frameworks to inform, not define, their research. Qualitative studies focus on theories and frameworks that allow for inductive reasoning (Padgett, 2009). Grounded theory methodology in particular encourages a framework that is open to interpretation and that is utilized as flexible rather than fixed in its interpretation of findings. Grounded theory has its origins in the social sciences and sociological inquiry that explains its focus on engagement, observation, and learning from the participants. This approach encourages the exploration of sensitizing concepts through literature review to inform and account for the researcher's initial impressions. Charmaz (2006) has referenced a theoretical framework or a "sensitizing concept" as an initial idea that can be utilized as a starting point of reference, but ultimate use needs to be determined by the synthesis of participants' data and the researcher's interpretations. Grounded

theory searches to learn from the experiences of participants and whether a common element can be identified among the experiences to inform future practice and theory (Charmaz, 2006).

This grounded theory study provided the opportunity for school social workers who worked at school districts that experienced targeted gun violence to share their experiences of providing crisis response and recovery support services to students, faculty, and community members. The purpose of this study has been to describe the experiences of school social workers who have experienced targeted gun violence at their school district and to identify any common themes in their response to the needs of the students and school community. In addition, this study explored the ways in which the social workers were impacted professionally and personally by experiencing a shared trauma with those to whom they provided services.

Eligibility and Recruitment

Eligibility Criteria

- School Social Workers employed by a district/school in the United States at the time of the targeted gun violence or a social worker contracted or hired in the immediate aftermath of the shooting.
- Participants needed to have their MSW.

Recruitment

Twelve school social workers practicing in school districts that experienced a gun related violent event or who were contracted/hired by school districts in the immediate aftermath were identified through multiple recruitment methods for participation in this study. For purposes of this study, targeted gun violence as defined by the US Secret Service is gun-related violence in which the attacker selects the target prior to the attack (National Threat Assessment Center, 2019). This study used purposive and snowball sampling to select participants who had

experienced targeted gun violence in schools. Given the pervasive and expansive nature of targeted gun violence in schools, recruitment was initially designed to identify participants that could reflect the varying socioeconomic and geographic characteristics of schools in the United States. Outreach to multiple national professional organizations was made and a recruitment post (Appendix B) was distributed through the California School Social Work Association (CSSWA). Multiple recruitment posts on school social work and school counselor related social media groups were created (Appendix B). No response was received as a result of these expansive recruitment efforts. More focused attempts were initiated through direct email outreach (Appendix A) to the social workers of schools who were known to have experienced targeted gun violence during the last 10–15 years. Impacted schools were identified through the Gun Violence Archives (https://www.gunviolencearchive.org) and Every Town for Gun Safety website (https://everytownresearch.org/maps/gunfire-on-school-grounds/). School social workers who were listed on the specific school websites were contacted via email to provide them information about the study and request their participation. No response was received through this recruitment effort.

Upon consultation with the Dissertation Committee, it was determined that more direct and connected recruitment efforts were needed. Given the publicity of the school shootings, potential outreach from other researchers or media, legal concerns, and the trauma associated with the horrific nature of shootings, it was surmised that school social workers maybe hesitant to respond to outreach from an unknown party. This researcher contacted colleagues and national experts in the topic of school crisis response and recovery to request facilitation of connection with school districts and individual social workers who had these impacted schools. Collegial contacts provided introduction to three impacted schools in which initial participants

were identified and interviewed. Snowball sampling was then used as the initial participants recommended and referred the researcher onto other participants.

Data Collection Methods

The interviews were conducted in a semi-structured format that allowed participants to explore this topic openly. A consent form was emailed for signature to all participants prior to the first interview to indicate they understood and agreed with the details of the study (Consent form - Appendix C). The interviews were conducted via Zoom at a time and location convenient to the participants. An email with a private Zoom room link was sent to participants and the interviews were recorded with their permission. The interviews were conducted via Zoom at a time and location convenient to the participants. Participants were given the choice to leave their camera on or turn it off. For deidentification purposes, participants were asked to provide a pseudonym that could be used on the Zoom screen during the interview and associated with their data in order to protect confidentiality. Participants were offered a $15 Amazon gift card upon completion of their two interviews. Interviews were recorded and transcribed by Rev Transcription for analysis. Information obtained from all participants was reviewed after the first interview and follow-up clarifying questions were asked during the second interview to ensure accuracy. Each interview lasted approximately 45–60 minutes.

Design of Interview Guide

Given the sensitive nature of the subject matter, extreme care was exercised to avoid retraumatization. The interview guide (Appendix D) was developed to explore both the research questions and the sensitizing concepts of the two theoretical frameworks selected for this study. The researcher reviewed the initial draft with a peer consultation group and the dissertation chair. Feedback was incorporated and then the second draft was presented to the content expert on the

dissertation committee for review. Questions were modified and reordered to assist with flow of the interview and to obtain pertinent study-related information. The researcher consulted with a context expert regarding concerns about retraumatization and strategies to facilitate the collection of data in a trauma-sensitive manner. At the beginning of each interview, participants were reminded that they had the option to take breaks or end the interview early if needed. Participants were provided an advanced copy of the interview guide upon request.

Human Subjects Research

The principal investigator of the study obtained approval from the University of Pennsylvania's Institutional Review Board (IRB) to conduct the study in June of 2021. An amendment to the inclusion criteria and revised informed consent form (Appendix C) was approved by the IRB in October of 2021 in order to expand inclusion to social workers who were contracted/hired in the immediate aftermath of the shooting. Informed consent forms were provided to participants and included the following standard components: purpose of the study, potential risks, benefits of study, confidentiality of records, and who to contact with questions or concerns. It was noted in the consent that due to the sensitive nature of the study, participants may experience some emotional discomfort discussing their experiences providing crisis response. Procedural information was included in the consent form if participants experienced emotional distress and wanted continued support after the interview. Regarding risk to privacy – data collected from the interviews was deidentified and stored in a password-protected computer. Any data that was shared with dissertation mentors or collaborators was thoroughly deidentified.

Data Analysis Methods

Once interviews were completed, the primary researcher, with the guidance of the dissertation chair, used an inductive method of coding to identify themes within the transcribed

interviews. According to Padgett (2009), "Grounded theory entails inductive coding from the data, memo writing to document analytic decisions, and weaving in the theoretical ideas and concepts without permitting them to drive or constrain the study's emergent findings" (p. 34). During the first step of analysis, the primary researcher reviewed the initial transcriptions with the recording audio to ensure accuracy and completed field notes. Open coding was completed for each transcription with descriptive identifiers noted in the margins to capture the words and experiences of the participant (Day et al., 2017). Review of these codes was completed with the dissertation chair with the goal of more focused coding to identify repeating themes. Codes were identified, combined, modified, or deleted as appropriate. These codes were then utilized with additional transcript to determine their applicability. Constant comparative analysis assisted with identification of relevant themes until the point of saturation (Padgett, 2009). Saturation occurs at the point when themes have emerged to the point of redundancy and no new information can be obtained. With guidance and review from the dissertation chair, a Code Book was developed and categories were identified within each theme. The code book was then reviewed with the content expert on the dissertation committee for feedback. The primary researcher then recoded all of the transcripts deductively with the aid of the codebook. Codes from each of the transcripts were then collected and bucketed together for ease of analysis. Findings were compiled based on those themes that met a point of saturation and the codes that pertained to those themes.

Table 2: Codebook Including Sensitizing Concepts and Inductive Codes

SENSITIZING CONCEPTS	THEMES	INDUCTIVE CODES	DEFINITION
Relational Cultural Theory –	**The Power of the Relationship/Connection**	Connecting Via Shared Trauma	Captures the organic ways that "the most impacted" parents, staff, and social workers used relationships with each other to process grief and trauma. Including

growth-fostering relationships, connection versus disconnection, mutual empathy, relational resilience, and mutual empowerment			creating a nonjudgmental space, starting slowly and working toward debriefing. Also, the way in which impacted schools connected with each other after their respective shootings – "the club no one wants to be a part of." Negative case: Ways in which social workers and parents used their grief from an insider/outsider perspective to enable disconnection.
		Coping with Secondary Traumatic Stress/ Vicarious Trauma	Captures the social workers' range of strategies to build community both with the students they support and with each other to process the trauma of the shooting. Those social workers who had the opportunity to debrief/process appeared to minimize their Secondary Traumatic Stress (STS). Student groups and parent groups also organically gravitated toward the sharing of experiences. Strategies that social workers used to mitigate their STS including group process, somatic methods, mindfulness, individual therapy, and basic needs meeting. This code captures the "Talking with a War Buddy" idea. Negative: Ways social workers describe lacking the opportunity to debrief and process as a group- being isolated. Social workers using busyness and avoidance to disconnect from the experience resulting in boundary issues, personal impacts, physical disease, and emotional trauma. The idea that STS is unavoidable in this type of response work.
		Connecting and Dividing Through Social Media	Captures the way in which social media was used to improve communication about logistics and supports (funeral, memorials) as well as build a sense of unity within the community. Also, ways in which social media was used to spread rumors, conjecture, and divisiveness. Creating an environment of high stress for concerns of litigation.

			Captures the idea of "being under the microscope".
		Responding to Parents and Staff	Captures the range of strategies and approaches social workers used to form a relationship with the parents and the staff most impacted by the shooting. Including logistical planning (objects etc.) and giving choice/control. Negative: Ways in which parents and staff were "forgotten" or treated with a "cookie cutter" approach.
	Gaining Knowledge about Trauma	Realizing it is not a linear process	Captures the idea that crisis response and recovery is not a short- term intervention rather it is a lengthy process in which social workers are required to provide ongoing intervention and support. Specifically, reminders and "firsts" often require additional support or "resetting" the student & family. Captures the idea that this is "a marathon".
		Understanding the Coping of Trauma	Captures the concept of "most impacted" students, families, staff, and social workers based on several factors including relationship, proximity, and duration of exposure to shooting. Includes the ideas of protective factors (relationship/attachment) and the variety of trauma responses.
Ecological Systems Theory- Microsystem/ Mesosystem/ Exosystem/ Macrosystem Ways in which social workers and their environment	**Working Within Systems**	Needing Specialized Supervision	Captures the supervision strategies social workers received/provided that enhanced their work with students/staff/families and mitigated some of their STS. Includes accessing national experts on crisis response and recovery. The idea of nurturing or knowing that they are "being held".
		Communicating Response/Recovery Efforts	Captures the methods in which social workers communicated with students, families, colleagues regarding crisis response and recovery. Communication

from a systems perspective was impacted by the shooting. Interventions across systems level			deficits top/down- administration to social workers, other staff, and families.
		Buffering Others From the Stress	Captures the use of "buffering" as a form of protection used by supervisors to social workers and from social workers to students & families. There are layers of buffering occurring
		Recognizing the "Insider vs. Outsider"	Captures how perceived outsiders are initially received by the school communities and strategies for successfully embedding within these systems. Also, what constitutes someone as an "outsider"
	Creating/Preparing the School Social Worker	Building Upon Basic Social Work Skills	Captures the range of micro and macro interventions/strategies social workers used when responding to the crisis initially as well as ongoing trauma treatment including building upon basic social work skills and clinical instincts. Also includes the pattern of "not knowing" the actual name of the intervention used. Social work is not just instinct. These are basic and advanced practice skills.
		Learning Through Field Education & Practice	Captures the trend that crisis intervention and trauma responsive strategies were developed in the MSW Field Practicum setting or in the initial stages of practice in their first jobs. In addition, self-awareness and boundary management that resulted from the experience of process recordings and good supervision. Idea that field practicum or work experience in a trauma responsive tertiary setting or one in which is nested within complex systems is beneficial.
		Understanding the Importance of Language	Captures the importance of language choices especially when working with families most impacted. For example, the use of the following terms – anniversary, event, triggered, lost, passed, incident. Some social workers are using these terms without the knowledge that some families find these words offensive.

Trustworthiness and Rigor

Rigor and trustworthiness are essential characteristics of qualitative studies if findings are to be confidently extrapolated to inform future practice and theory. Trustworthiness focuses on what measures or safeguards have been implemented to ensure that the findings adequately capture the experience of participants. Padgett (2009) has referred to Guba and Lincoln's (1989) definition of trustworthiness as "one that is carried out fairly and ethically and whose findings represent as closely as possible the experiences of the respondents" (p. 212). In order to increase rigor and trustworthiness, this study included the following measures. All potential participants were screened in advance of the interview to ensure they met study criteria and were able to participate. The researcher conducted multiple interviews with each participant to facilitate prolonged engagement and allow for follow-up and clarification questions.

Peer debriefing and support was another safeguard measure that was utilized in this study to protect from researcher bias. An experienced qualitative researcher and tenured professor at the University of Pennsylvania School of Social Policy and Practice supervised development of the interview guide, coding of data, and analysis of findings. A content expert in school trauma and Clinical Professor Emerita from the University of Southern California Suzanne Dworak-Peck School of Social Work with experience in targeted school gun violence was a member of the dissertation committee and reviewed the interview guide and the findings. A reflexivity journal was maintained to prevent bias and to buffer the primary researcher from vicarious trauma. The researcher also self-identified as a doctoral student in all communications regarding recruitment and participation in the study. The primary researcher's educational experience includes completion of a master's level program in social work from Columbia University. The

researcher holds an independent license in clinical social work (LICSW) in the state of Rhode Island and completed the training on working with human subjects through CITI.

Reflexivity Statement

Reflexivity is a critical aspect of qualitative research to recognize the strengths and limitations of a study. In order to manage bias and protect against vicarious trauma, I utilized a reflexivity journal on a weekly basis to record interactions, concerns, and feelings that arose from the research. In addition, I processed thoughts and feelings around the study with my dissertation committee on a regular basis. Near the completion of data collection, a school shooting occurred in Michigan killing four and injuring seven students. For several weeks after the shooting, I was hyper-focused on media coverage of the shooting and the response efforts. I experienced thought rumination on the experiences of the study participants and what the social workers at Oxford High School might have been experiencing in the aftermath. I processed these feelings with my dissertation chair and explored them in depth through the reflexivity journal. I also decided to limit viewing of media coverage about the shooting,

My professional experience and training allowed for both strengths and potential biases for this study. Professional experience includes K–12 school social work, private practice, forensic diagnostic adolescent evaluations, and MSW social work education.

As a former school social worker and a current educator in a MSW program, my professional experience provided the credibility that allowed participants to fully engage with interviews. In particular, the school social work experience allowed me to empathize with the participants and potentially gain their trust; however, I was always aware of the need to remain cognizant of not taking ownership of their stories (Crozier, 2003). In order to gain this trust, I engaged in a certain degree of self-disclosure by stating that I was a former high school social

worker. According to Crozier (2003), being "willing to share my experiences and identify with the respondents as much as possible in order to diminish the barriers and equalize the relationship" can contribute to trust building (p. 86). My experience as a clinician was beneficial in navigating the amount of disclosure versus maintaining professional boundaries. Also, the ability to be self-aware assisted in engaging in thorough reflexivity as this was important to how the subjective and intersubjective factors impacted the research (Finlay, 2002). My clinical experience also included ongoing trauma work with adolescents, though not necessarily those who have experienced gun violence, which provided the background knowledge to engage with social workers regarding their stories around the violence, its aftermath, and what supports/additional training around trauma they needed.

A significant bias I was vigilant about was my social work education experience and my codevelopment of a trauma-focused school social work training within my university. This is a summer session training that was developed to enhance the learning of students within their field practicum. I was careful not to assume that the existence of the training warranted the necessity of it prior to conducting this research study. I was vigilant in maintaining a nonbiased stance through reflection in the reflexivity journal and through discussions with the dissertation committee.

CHAPTER SIX

Findings

Participants included twelve MSW social workers who were either employed by a school at the time of targeted gun violence or contracted/hired in the immediate aftermath of the shooting. Due to the sensitive nature of this topic, demographic information about participants and their respective school communities will not be revealed in order to protect their identities. Also, any specific experiences shared with regard to supporting students, staff, families, or the community that included any information that could lead to identification, were not included. This study examined three school districts that experienced targeted gun violence during the 2010–2020 time period that resulted in death and/or injury of student(s) and/or staff. Participants provided crisis response and recovery support to students, staff, parents, and their school communities. The researcher interviewed multiple social workers from each school shooting to prevent a single point of view of the experience. Participant transcripts were deidentified and pseudonyms were assigned to the data to protect confidentiality. Out of an abundance of caution, findings will be noted only with reference to the term "participant". The following is the breakdown of participants per school district and by years of experience post MSW.

Table 3: District and Participant Practice Experience

District Identifier	**Number of Participants**
School # 1	5
School # 2	5
School # 3	2

Number of Participants	Years Post MSW
3	5 years or less
2	6 years to 10 years
3	11 to 15 years
4	Over 15 years

Three major themes emerged from participant feedback: the power of connection, the impact of trauma, and the gaining of social work skills/knowledge. The importance of connection will be interwoven throughout exploration of these themes and aligns with the proposed theoretical framework for this study, Relational Cultural Theory (RCT). The findings are organized to answer each proposed research question and each section has been divided into key areas or codes that emerged from the data.

The Power of Connection

One of the major themes that emerged from this study, which was noted in previous studies, was the importance of connection. In particular, Hagman (2017) in the first-person narrative of the Sandy Hook response noted that his team of community-based crisis responders focused on building relationships with students, parents, and faculty within the school. Hagman described the intensity of the response and the need to build trust through forming relationships. All of the participants in this researcher's study confirmed Hagman's assertions and recognized that regardless of the interventions utilized, relationships were at the core of all of their work. One participant stated that social work in particular acknowledges the importance of the relational aspect of the work and its importance in particular in crisis response.

> *It's starting where the student's at and building that relationship with what's present in the room, with the student. And working with the student really to build that relationship and solidify a sense of trust. Everything is relational, right? Every single thing that we do with them is relational.*

Participants also acknowledged that throughout their work whether on a micro, mezzo, or macro level, they observed students', faculty's, and parents' desire to connect with each other as peers who understood each other's experiences. Participants also expressed that they found comfort in connection with other colleagues, especially to manage the impact of the intensity of the crisis response. Specific questions about the day of the shooting were avoided to prevent retraumatization; however, several participants spontaneously shared their experiences of that day to illustrate the overwhelming nature of community trauma.

How They Learned About the Shooting

Several participants shared how they learned about the violence that occurred in their schools. Three participants across two districts described that they were in trainings and a team meeting while at different school sites when they learned of the shootings. These three participants shared the initial disbelief of learning that this type of violence had occurred in their school district. One described the shock of the initial news that there was an active shooter.

> *One of the leaders told us "There's an active shooter at (NAME REMOVED)," and immediately I went into shock mode because I'm like, "That can't be. No way." We went to another building so that we could receive more information, and one of the students' videos from I think on SnapChat or something like that, got released to the news media.*

We saw it, the video of the students laying there on the ground and saying, "Our school is being shot up."

All of the participants mentioned that although they were aware of the rise in school gun violence that they initially experienced disbelief and shock that such violence could actually occur in their specific community. A participant recalled being in lockdown and supporting the students in the room. It was mentioned that all the schools within that district went on lockdown during the shooting.

I had students in the room with me during the lockdown. So my crisis response was really supporting them within the moment, and obviously engaging in safety parameters that we were trained in regards to any type of gun violence, where you move furniture in front of the door, all that kind of stuff. And then huddling with them in an area that was pretty away from windows.

Although not all participants volunteered the specific details of when and how they learned about the shootings, everyone was willing to share their experiences with regard to the crisis response and recovery specifically what social work interventions were the most effective and how they managed the symptoms of STS during the response.

Initial Crisis Response

In all three school districts, there was loss of life and injury that required immediate response including death/injury notification and psychological first aid in the subsequent weeks. Participants described the immediate phase of crisis response after the shootings in which there were temporary locations set up to provide psychological first aid to students, families, and community members. The days were long, 10–12 hour days and seven days a week. For some the initial crisis response lasted a few weeks, but for others it was sustained for several months.

Participants from all the districts described the first few weeks of their respective responses as being the longest hours and the most fast-paced work. One participant shared what the first day of crisis response felt like at their school.

> *I remember very clearly the first day that it happened, I went to the hotel and I was with the families and I was there until about 2:30 in the morning, and I definitely had that sense of all in the same night. I had that sense of the time passing quickly and time moving slowly. It's a lot of anticipation because they were waiting to hear about their children. I'm trying to think after that, it felt like things were, I guess it felt like things were moving quickly, but I just wanted it to be over. I just wanted that, that anger to go away. And I just wanted, you know, for things to be resolved and for us to do the work that we needed to do and to be trusted.*

Those in leadership positions explained that even with advanced preparation for crises when a community is faced with such violence it requires flexibility, trial and error, and attention to not only the individual, but also the community. Two participants proposed the idea that no preparation can prepare for this type of crisis response so quick adjustments to approaches were expected in order to meet the rapidly changing needs of the community. One participant described the initial crisis response and the in-the-moment adjustments as feeling like:

> *We were changing the tires while driving 80 miles an hour. That's what our initial response felt like. We were definitely driving fast and doing maintenance on the car at the same time.*

Two other participants used different analogies to capture what the initial response felt like:

- *It was just chaos. I think the train kept moving full speed ahead constantly. It was busy. It was intense.*

- *Initially afterwards it was all hands on deck all the time.*

In addition to fast-paced and changeable, the immediate aftermath was also described as emotionally draining as the work often did not stop at the end of the day because preparation for the next day was necessary. Several participants especially those in leadership positions described how the response extended into their family time at the end of the day.

> *During that time, you worked so many hours and then you'd go home and you'd have to talk on the phone about debriefing the day and what's going to happen tomorrow. It was no time to talk about anything. I had family members reach out to me. I just said, "I'm really busy. I can't talk right now." I really went into go mode, and I just kept going and going, and going, and going, and going.*

Participants whose primary responsibilities focused more on direct practice with individuals described the intensity and the overwhelming emotional nature of the work. When asked to describe the experiences of that time, one participant described the difficulty capturing the essence of the feeling they experienced:

> *It was so big. I can't find the words. I can't describe it.*

Another participant recalled the intensity of the scene supporting parents and students who were traumatized by the violence.

> *It was at times overwhelming when everyone is traumatized and you don't feel like there's a lifeline, it can be really overwhelming.*

This participant mentioned that the amount of need in the community was large during this time due to the impact of the shooting – no one was left untouched by this violence. The depth of pain, distress, and shock was intense for many of the participants. One equated the work to being a first responder:

> *We are on the front lines. I don't think we think of social workers often as first responders. Maybe we're not "first" first responders. We may not be there when the ambulances are arriving, but we're there a very short time later. Essentially first responders. We just pull up in our own personal vehicles.*

This participant introduced the idea that social workers are "emotional" first responders. They may not be exposed to the physical scene of the violence, but they are often present during the immediate aftermath when victims require emotional triage.

Personal and Professional Impact of Crisis Response

A dominant finding across all interviews was the experience of coping with Secondary Traumatic Stress (STS) or Vicarious Trauma (VT). This included how participants learned of the shooting, the intensity of the initial response, the symptoms of STS or VT they experienced, and what they learned about coping with STS and VT. Participants used the terms Secondary Traumatic Stress (STS) and Vicarious Traumatization (VT) interchangeably during the interviews to describe emotions, thoughts, behaviors, and change in worldview both in the immediate response and during ongoing recovery services. This researcher offered both terms during questioning and allowed the participant to select the term which most resonated with their experience; however, for the purposes of this study the term STS will be utilized. Every participant in the study indicated that being part of the response and recovery efforts had impact professionally and personally.

One participant shared:

> *I do think with vicarious trauma, there really is a cost to caring and there is a cost to being compassionate. I don't think you can really prevent the vicarious trauma when you're doing disaster response.*

This participant's statement introduced the idea that STS and VT may be unavoidable in response and recovery work especially in cases such as school shootings. One of the questions this study hopes to address is how can social workers navigate providing crisis response and recovery to others while maintaining their own well-being. In what ways can the risk of STS and VT be managed?

Symptoms of Secondary Traumatic Stress and Vicarious Trauma

All participants felt the impact both professionally and personally of response work whether it was physical symptoms, sleep issues, tearfulness, over-interest in media coverage of the shooting, or disconnecting from their families. One participant discussed the impact specifically on the health of herself and colleagues noting frequent colds, physical symptoms, and pre-existing medical conditions exacerbated from the chronic stress of the situation.

> *People were getting sick, physically sick internally, whether it was their gut, their stomach, their heart palpitations. We saw it in each other and we talked about it, privately. I wish I would've had a better self-care regimen myself. Not recognizing the impacts that it would have on me personally and physically.*

This participant continued to explain that it was a few months after the shooting that they recognized the need for better self-care. In addition to physical symptoms, another participant from the same school district recognized the cognitive impact of STS:

> *One thing that I have recognized is that I realized that during that time, you know, how they say you get that like fog, trauma fog or whatever you call it. I was thinking at the time, why can't I keep up with what everybody's talking about? Like why, why am I not remembering these things? And I would write everything down and now I realize that it*

> *was a fog and that there was just information overload and plus the trauma of everything that had happened.*

This participant who was trained in trauma studies was eventually able to recognize that they themselves were impacted by the trauma of the situation. They may not have been within the specific school that the shooting occurred at, but they were part of the school community and they were exposed to details of the shooting within their response effort.

A participant described the emotional impact of STS describing a time when they felt overwhelmed during a meeting:

> *The message was given that we should all take care of ourselves, that it was okay to seek therapy. I was sitting in group supervision and I just kind of really broke down and I lost it and I was like, okay, I think I should not hold this all in.*

This participant accessed support services and engaged in self-care, but still felt emotionally impacted by the weight of supporting students and staff during this time. The toll of being exposed to the stories of the shootings over and over was traumatizing for many of the participants. About one third of the participants disclosed that they engaged in individual counseling during the response and recovery as support.

The Impact of "Holding Space"

When describing the initial crisis response, all of the participants mentioned social work skills such as holding space, starting where a client is at, active listening, and linkage to community resources. Many of the participants discussed the impact of hearing the students and staff's experiences of the shooting in detail during this time. These participants also recognized the need to "hold space" and the therapeutic value of allowing other to share their stories. The

frequency and graphic nature of the details were often quite heavy for participants. One participant shared:

> *I feel like I carried it around with me. It was heavy, but I also feel like I held a lot of space for people so that it became kind of heavy. It did impact my sleep a little bit. Um, just a lot of my kids wanted to retell their experience and it was like I was vicariously reliving their experiences.*

Another participant who was a supervisor recognized their and their clinicians' exposure to potentially traumatizing work over a prolonged period of time:

> *In those first six months in particular, they were really starting to hear some of the more intense details and memories of what kids recalled.*

This participant expounded on this by sharing the experience of mutual empathy as they are a parent who has children in a similar grade level as some of the victims. Many participants shared that they held these stories in confidence either because they had concerns over confidentiality; they were concerned that others could not tolerate the horrific details or they lacked the opportunity to debrief on the content they were hearing. A participant stated:

> *I can't talk about it with people I know because everybody knows everybody. I don't speak about it at home with my family. I'm very careful about confidentiality and everybody's an identified person. It's not unknown who the people that were impacted are. So, I don't speak about it often and so that left me with a lot of information and nowhere to go with it.*

With no way to process, this participant acknowledged the traumatic impact of holding such horrific stories and details of the shooting.

Several participants acknowledged that at the time it was a conscious choice not to process the personal impact of the stories. They recognized that they were experiencing STS and that it was easier to compartmentalize and seek help at a later time when less busy. Several participants noticed in others as well as themselves the tendency to avoid discussing or acknowledging the emotional impact of their work. The idea of social workers being too busy to process emerged across the different narratives. One participant equated being busy as just part of being a social worker:

> *I'm a social worker. So, when there's any type of challenge or tragedy, I'm a doer that's how I maybe avoid processing myself, is I'm actively doing and I was actively doing even that day. People would ask me all the time, "How are you doing?" And I would say, "I'm fine. Let's talk about something else." You know what I mean? That's kind of like, "I'm fine. I'm fine. Don't worry about me. Let's worry about these kids." I think it was a while before I was able to even turn the focus to myself. There was just too much to do and I didn't have time to think. I would get a call, "We need you to do this," and I'd be like, "Okay. Yes." I never said, "I can't." I never said, "I want." I just said, "What do you need me to do?"*

Another participant echoed this sentiment:

> *It's just that I knew anytime that someone would want to talk to me about it, that that would, you know, cause me to like be there with my feelings. And I didn't really have that time at that time, you know, there was a lot going on.*

These participants acknowledged their choice not to process their feelings during the experience, choosing to compartmentalize instead. This coping strategy is not uncommon to first responders in general.

Impact on Boundaries

In addition to avoidance of processing, a pattern of boundary management difficulties emerged. Four participants across two of the school districts reported they observed their colleagues either being overly involved or conversely exhibiting disengaged behavior. Several participants mentioned they noticed that some colleagues, especially those who were in the buildings or were familiar with the victims, experienced issues around boundary management. One participant explained:

> *There were certain colleagues that it was harder for. Yes, definitely. Most definitely the colleagues that were there the day of - that was very difficult for them. And I could see where they were putting their heart and soul into it. And you questioned the boundaries a little bit because it had been so close to them, not in an unprofessional way, but just, you know, in terms of our role, like you, you knew you were going above the, what the client was offering, you know, that kind of a thing. People taking things personal and obviously we don't take things personal in this profession, we're trained not to and you knew you could see it on some people.*

Boundary management was discussed with several participants who acknowledged that at times working with the most impacted students, staff, and family was challenging for them because it required a depth of relationship that was needed to establish the necessary trust to develop a therapeutic alliance. The concerns expressed about boundary management were not in regard to a violation of social work ethics rather it was an overinvolvement with the students and

families – for example being available to assist at all hours and offering support outside of the normative school social work roles. Those participants recognized that the extensive impact across their community as well as the horrific nature of the violence required that they go "above and beyond" their normal responsibilities.

Conversely, other participants observed some colleagues disconnecting and avoiding deeper interactions with the students and colleagues. Essentially, "clocking in and out" without much interaction with others. One participant was able to identify this as likely a protective factor for those colleagues.

> *Some people would just, you know, come in and leave as far as clinicians and not, not even take notice of what these other people have been going through. They were just so like detached, you could see the people that just came in, they do five hours of therapy. And then they just walked out. They were almost like robots. Like they weren't, they weren't allowing them in. And it's a protective factor. If I look back, they weren't allowing themselves to be involved in the how does this happen? How does this play out? How does this close down? And so, there was these other individuals that just would come in and go out and not even communicate.*

A participant acknowledged their difficulty with connection during that time due to the feeling that others would not understand the experience.

> *I think like in general I was a lot more tired. I think that it was difficult to connect with people after that. It was hard to think about... Like we've been through this huge thing and then people that are trying to support you... I couldn't talk about it because everybody would try to understand and it would be difficult for them too, and I didn't want the trying, I wanted somebody to actually get it. I just kind of disconnected from*

> *people for a while, because it was easier to disconnect from people. I just had lot of emotional disconnection. And then I also tended to avoid it. When I was outside of work, I didn't want to talk about it, I didn't want to deal with it either. I would just kind of avoid people and things.*

This participant reported that as the response moved from crisis to more recovery oriented that they were able to re-establish connection with colleagues, friends, and family. Relational Cultural Theory (RCT), the guiding theoretical framework for this study, posits that acute disconnections are not problematic if addressed and not chronic in nature. Due to the lack of mutual empathy in which this participant "felt attunement" with others, they felt the need to disconnect as a coping strategy.

The Importance of Self-Care

The majority of participants recognized the need for self-care during that time and that in retrospect they could have benefited from using support resources, but felt that time did not allow during that phase of the response. Being too busy for self-care is not necessarily a pattern specific to the participants responding to these tragedies, rather "self-care" is an activity that social workers are notoriously deficient with and was recently addressed by the National Association of Social Workers (NASW) with the addition of self-care into the professional code of ethics. Two participants from different districts commented specifically about MSW education around self-care:

> *When I think about self-care and disaster work in particular, I think about how we tap out, how we have to tap out. I don't think that's something we talk about, especially in an MSW curriculum. We definitely are always talking about how to tap in.*

The second participant pointed out the lack of self-care emphasis in crisis intervention.

> *And I don't think that's considered much when we talk about crisis intervention. We talk about how to help support and how to help respond and react to everybody else's crisis, but not much of our own.*

The participant continued by explaining that their experience has been that self-care is encouraged in both MSW programs and employment settings, but rarely is the social worker afforded time during the work day.

> *I think that self-care in general is not taught well in a social work program and outside of it, and the whole world is so gung-ho about self-care. And then we put pressure on people and on jobs, and have these requirements and have these things, and don't allow for it, and have these like stigmas behind taking care of yourself……..So, there's a big talk of self-care, but self-care has to be done on your time, not on anybody else's. So, if you're in school or you're at work, it can't be done in school's time, it can't be done on work's time, it can't be done.*

This participant continued by expressing the opinion that there is not enough education on the different forms of self-care and how to incorporate them into the work.

> *I think that social workers need more time for self-care, and I think that the nature of our jobs and the way that they're structured and the risk responsibilities that are asked of us, for all kinds of social workers, not just school social workers, I think that it allows for less time to practice self-care, despite being one of the professions that needs it the most, and I don't think that there's good enough training and support on all the different kinds of self-care, and what self-care can look like, the self-care that we need along with the self-care that we want.*

The problematic aspect of this pattern specifically with crisis response and recovery is that the work itself can be inherently traumatizing and lack of self-care increases the risk for STS. The participants interviewed for the study were all offered support services from their districts which ranged from Employee Assistance Program (EAP) counseling, additional onsite individual counseling support, yoga, mindfulness, and various wellness-oriented activities. A few of the participants were actually involved in developing and implementing the wellness and support services for their peers. Several of the participants engaged in some of the offered supports including wellness activities and yoga during the recovery phase of the response, but many reported that they were unable to engage during the initial crisis response. As the response shifted from crisis response to recovery, the mindfulness activities were utilized by more of the participants. Terms like the practice of "being present" and "grounded" were reported as being helpful for them. One participant referenced that they arranged their office with visual reminders that grounded them as well as engaged in mindfulness activities at the start of each day.

> *I just had to center myself because I want the day to go well for the people I serve, but also not be this chaos inside of me that I can't fix everything. I had these little visual triggers that center me, that ground me. And then I have, I use the media to watch 10 minute mindfulness body scans visualizations throughout my day. And I use also these skills in session, depending on where the child is in the process and sharing it with the child, I'm doing the exercise too. That benefits both. I did not have that in the past. I didn't access it. And I access it all the time now.*

This participant reported that the mindfulness activities that they had learned were serving a dual purpose both as self-care and as new skills in their intervention toolbox. They were able to integrate this self-care practice into their work hours.

Protective Factors With STS

All of the participants were able to identify protective factors and coping strategies that helped them in managing the secondary traumatic stress surrounding the response work. Several participants mentioned the importance of good sleep and dietary habits. One participant noted that during the first year of response, they relied on their spirituality to help them cope with the tragedy and hearing the details of the survivors' stories. Another coping strategy reported was limiting exposure to social media and the news. A participant mentioned that both contained some disturbing imagery and that stories reported were often not always accurate. In order to protect themself from this stress, they consciously limited their access to these potential sources of information. Another participant discussed the importance of healthy boundaries and emphasized that a social worker can still be compassionate and engaged, but not be disconnected or indifferent to the work.

The importance of friends and collegial support emerged also as important for many of the participants. One participant described how their family members assumed some of their household responsibilities and that their family avoided asking them questions about the crisis work.

> *I had really good support that I don't know what I would have done without. I know that there were people, you know, when they knew I wouldn't talk to them, they would just call me and say, I'm thinking about you, if you need anything, let me know. My husband kicked in, you know, so, and my children also very, very supportive. I was very fortunate*

that way. I had a lot of people surrounding me. And, also there was a level of camaraderie with the people I was working with - we were kind of in it together as well. So, there was that support that was really incredible, very, very helpful.

A participant from another school echoed similar sentiments with regard to friends and family as well as noting the importance of their supervisor's support.

Yeah, it was exhausting, emotionally and physically exhausting. I remember going to bed at seven, and thank God I have an amazing colleague that really helped support me through this process. And also, a boss, our director who was very supportive, and then just the network of support with my family and friends, I think, really helped support. But I remember being exhausted and coming home and having little ones, but just not really being there, being present.

Another participant from the same district also noted the protective factors of collegial friendship noting that they felt comfortable processing the experience with them.

I have a really strong network, friend network that are also social workers, who I think can tolerate hearing some of our stories of our work. And I'm grateful for that.

A participant from a different school acknowledged the support from a family member who was employed in a helping profession position and understood the nature of crisis and trauma response. Several additional participants across all the districts recognized that they were able to process their feelings with someone whom they felt understood their role and could tolerate the nature of the stories they shared. Those who reported that they had the opportunity to process their experiences during or shortly after the immediate response appeared to be able to minimize the symptoms of STS/VT.

Processing the Experience

Of all the coping strategies and support resources that participants shared, the opportunity to process their experiences was identified as most helpful. All of the participants engaged in some form of group supervision during the weeks and months after the shootings. Much of that supervision was reported as case consultation-oriented only; however, several social workers from one district were offered a group processing meeting with other clinicians to explore their feelings during the beginning of the response as well as an additional meeting offering the opportunity to assist school staff with processing their feelings. One participant described these experiences as comforting:

> *It was all teams joining the social work team, the department of counseling with the counselors, the therapists within the schools. Some are MSWs, majority are MFTs, but all of us supported staff, students and community, whoever attended this support service with all these therapists. And I think in those moments, in the moments of downtime, if there was any, or prior to, there was a team process, not supervision, but a team debrief of it with colleagues. And then also prior to it being open up to the community, we held an event specifically for staff that were impacted by it with all the therapists and social workers in the room and offered up an emotional process to debrief about their experiences, their narrative of what occurred for them, that kind of thing. So, that in a way it felt almost comforting. You know what I mean? In a way where we all were in a room processing experiences and stories and narratives and providing hugs to one another, or us pulling aside a staff member to support them in the moment.*

This participant identified these two opportunities as the only official times to process their own feelings as a group; however, the participant was able to connect with a colleague on an individual basis that provided similar support and opportunities for emotional processing. This

connection occurred organically and was stated as an important source of support. The participant described the benefits of the connection:

> *I think we were both go, go, go with how to support. What we can do, do this, this and that. And then in the moments, I think it did happen organically. In the moments, it wasn't like, how could I support you? She vented, right, or shared or identified how exhausted she was. And I validated it and shared it as well and what we need to do for ourselves and how we need to go home and get support. It was more organic, not a professionalized, let's sit down and debrief about this.*

Another participant from the same district described how the support team within their school site developed their own processing group to check in with each other every day. They described this group as offering a confidential space to process feelings each day. This connection also occurred organically.

> *So, one of the things before we brought students back, our principal met with the support staff and, basically wanted to make sure that we were okay because no one else did that. I will say that everybody, as support staff, they expected us to support everybody else, but nobody checked in on us. Nobody said, "You also lived through it, not just the teachers and the students. You also lived through it." No one came and checked in on us. So, we did it with each other because no one did that for us. Usually, they'll bring other agencies to come and support the whole staff. They brought other agencies, but it was only to help us meet with students, not to check in on us as support staff.*

The participant explained how the support from this group of professionals revolved around basic physical and emotional supports.

> *And we would check in with each other, we would send a message in the morning, "Hey, just checking in, letting you know that I'm here if you need any support," or sending text messages throughout the day, "Hey," we were making those phone calls with each other. But where we really found support was at the physical school sites where we were at with our counseling team. In the mornings, coming in and just saying, "Hey, can we just do a quick check-in, like five minutes, and just talk and just see how are we feeling today? Anything. However, you're feeling, just share it, put it out there. Do you think that you're going to need extra support today? Let's make sure we take little breaks. Let's make sure we drink water. Let's make sure we eat. Let's make sure that if you're feeling a little bit overwhelmed because of the work, that you let us know and say, "Hey, I need help."" And that's what it consisted of. But it wasn't because it was led by any supervisors or any admin, it was led by the support team at the school sites.*

A participant reflected that most of the support options offered the chance to process feelings only in an individual setting through the employee assistance program or through outside clinicians who were offered onsite during the initial weeks. This participant was able to recall at the time she did not want to engage in these support resources and upon reflection realized that she would have preferred the opportunity to process her emotions with their own colleagues in a group setting.

> *We all know how helpful it is to talk about things and the feelings that you're not allowed to talk about. Something is almost more challenging for us to deal with and having to talk about hard things. So, any version of getting together as a group for support to talk about it, I think would've been helpful and well-received.*

During the second interview, this participant mentioned that the first interview for this study was one of the first times they had to process this experience. They mentioned they contacted one of their colleagues after the interview to discuss how cathartic it was to discuss the experience. They stated:

> *I reached out to one of my peers saying we should have done something like these years ago, just because it felt a bit, um, like cathartic to kind of just get some of these things off your chest about it. I guess it really was kind of a difficult experience. Um, but it was, I thought it was a helpful thing actually. And it would have been nice if we had done it sooner. I guess processing how we handled the experience because the processing we didn't do right. The debriefing we did was more centered on these cases, the situations, the day-to-day, it wasn't on - How are you doing? Or what would, what would have been more helpful for you? You know, because that actually could have made a difference in how we handled it. I think just looking at it as a whole, um, because it was such a big event, an awful big event, but being able to process, um, my experience personally and how it affected me as a social worker was helpful. I don't think I knew I needed it until I got it.*

Two additional participants from the same district mentioned during their second interviews for the study that this was the first time someone asked them to reflect on how the experience was from their perspective and that they found the interview helpful. One of these participants indicated that they found their own way to "debrief" with colleagues outside of the school setting during that time. They also recognized that some of their school-based colleagues were not availing themselves to any supports during this time. They stated:

> *I don't know if they kept so busy, they didn't have to process it. I, I think we were so busy. Some of us just made a point of prioritizing the debrief and the process because we knew if we didn't, it would be on our minds, you know, and we didn't want to go home with it.*

This participant continued to explain that she had learned the importance of debriefing from a supervisor at a former employer. They learned at that time their tendency to take the work home with them which they said led to feelings of compassion fatigue at different points in their career.

A participant had a slightly difference experience than their colleagues. They mentioned that in their specific department, their supervisor facilitated group supervision that had both a case consultation and a processing component.

> *I was very lucky to be in a group supervision-they were very supportive. We always gave each other attempt to be vulnerable. And I think that was what really helped is that we had created that environment to be vulnerable, but then also we had like would lift each other up and give each other that space and time to process things that were heavy or difficult. It had a has always been that way since I had been in supervision and our group supervisor kind of lets us kind of develop what we want group supervision to be. So, it just kind of morphed into this place of processing, but then also clinical case presentations and connecting theory to all of it. Um, so it just kind of developed into it. So, we all kind of brought a little piece of ourselves into it and then its kind of, she just let it flourish into what it kind of became. You really absolutely need a support system of people who know what is going on and that you feel comfortable with talking about your own vicarious trauma.*

This participant introduced the idea that group supervision could find a balance between clinical case consultation and processing of emotions. This participant also captured the idea that processing in a group setting could be therapeutic because it was a space in which vulnerability could be created and in which other group members could understand from a similar perspective. This idea is in alignment with RCT's assertion that during times of stress individuals will seek to engage in growth-fostering relationships that contain both mutual empathy and mutual empowerment (Jordan, 2018). The opportunity to process shared experiences with others who are in relational attunement allowed participants to feel understood and supported.

The ability to process, decompress, or debrief were terms that were used interchangeably by participants to capture the ability to ventilate their own feelings, discuss the impact of the work, and receive support from others who were perceived to understand the work. Whether they accessed these opportunities through other individual peers or through group supervision the common themes were safety, vulnerability, and the support. One participant encouraged every social worker to engage in processing preventively.

> *You have to be sure that you have a place to process it too. Like be sure to find a place. And before something like this happens, we as mental health professionals should have a place to process everything that we experience. We experience secondhand trauma from all kinds of things, not just from this, and I think it's really important for all of us to have a place to process that. I think that it's more general advice, just being in the field of social work, that social workers should have an established place to process their secondhand trauma. And when I say established, I mean like before something like this happens, because it's really hard to then have the motivation, the drive, or to even feel like it's necessary at that point to have somebody or someplace where they can process it.*

Specialized Supervision

All participants, both direct practice and those in supervisory roles, recognized the importance of supervision. Some preferred individual supervision while others reported group supervision was more helpful if there was both a case review and processing component. One participant explained the importance of supervision but stated that often during crises people are busy and supervision is not always a priority in the moment. All the participants who were in primarily direct practice roles recognized that their supervisors were very busy, were buffering them from the administrative stress, and were experiencing their own impact from the trauma. Conversely, the supervisors among the participants acknowledged their own shared trauma and ways in which they would provide support to their clinicians. One participant in a supervisory role shared:

> *So as the supervisor of the staff who were there, I had to really be checking in with my team a lot about their own wellbeing and the impact of vicarious trauma. And I absolutely know many of the... I mean, I know that they were deeply impacted by serving as I was. Am. As I am. Was and am. If that even makes sense.*

This participant mentioned how she would make outreach to her clinicians frequently or bring them concrete reminders that their work was valuable.

> *I would text in the morning or at the end of the day, or just, you know, thinking about how your day went, you're not alone, even though you might feel like you are some days. So that was just something I did intuitively. I knew to do that kind of reach out and the support.*

This participant expounded on this by giving examples of how they would make outreach during the later time within the crisis response.

> *Just staying in touch with people was helpful. I think also when I came on site, we regularly would go actually out for lunch together, pull them out of the school for a bit of time, which was nice. And also, just little things like... By the way, when you work in a school, there's a bunch of germs and so you get like colds all the time. I would bring like a bag of oranges for them in their office space, increase the vitamin C, and hand sanitizer.*

This participant later discussed the importance of simple concrete needs being met as a critical part of disaster recovery work and as a tangible symbol of support. They explained that when they initially report to crisis response settings that they observe the concrete needs of the victims such as food, water, and tissues. They added that clinicians often need the same kind of supports.

Another participant, who was in a supervisory role at a different school district, discussed that they would also offer similar ongoing support to the clinicians so they knew they were appreciated. This participant also discussed the stress of the environment and mentioned that they felt that part of their role as a supervisor was to buffer the clinicians from some of the stress from administration, politics of the response, and the community. One of the participants who was employed by this same school acknowledged this type of support from their own supervisor:

> *I definitely would call my supervisor if anything was politically driven or a teacher that was really involved in the media. Anything that involved anyone that was very big in the media did make me a little leerier and just make sure that I was very good with my documentation or didn't put certain things that I knew could affect the child negatively.*

This participant continued by describing how supervision was beneficial for managing risk assessment and navigating the politics of the situation, but they would have preferred more

opportunities to process their own feelings. They provided an example of what would have been helpful:

> *Hey, let's just talk about your feelings, anything that's affecting you negatively, you know, anything that came up that was political, I would call my supervisor and give her a heads up, but it wasn't like, Hey, how's this affecting you? Of course, you know, she had to deal with the management side of it kind of thing, the political side of it. I'd say maybe every six months you just kind of sit down like, and have decompression about what's going on in the school and how it's affecting you. Yeah, that'd be good.*

This participant described the first few months after the shooting as very stressful as far as navigating the politics of the situation and the anger from the community. They felt much of the focus on supervision at that time was managing social and political risk rather than "decompressing" as clinicians. The participant acknowledged that case consultation to manage risk was essential during that time as it was a tense atmosphere.

Several participants described how they felt both their needs for supervision and processing were met on an individual level. One reported that their supervisor frequently offered them support around boundary management and self-care around the shared trauma.

> *My clinical supervisor and I spoke a lot about countertransference, how we're taking care of ourselves because it was like we're a member of this community that happened to our school. Not just, we're not just a therapist in the school. I felt like I really used supervision and my group supervision to validate and process my feelings regarding what I was dealing with. I also did a lot of self- care. I slept a lot too. I think sleeping was probably the best. And then I seek my own therapy to just process kind of what I was processing every day.*

Another participant shared that their supervisor not only reminded them about self-care, but also helped them manage feelings of self-doubt.

> *I really didn't have a lot of experience with crisis intervention. I think that was my hesitation, but my clinical supervisor sat me down and she's like, you do have the training, we know how to ground people. We know how to do all of that. It was helpful for her to like, say it because it seems like a big undertaking for me. And she was like you do have these skills. I feel like that was helpful to have the support from my clinical supervisor and even though the world was spinning 17,000 times around us, that we were able to have a moment where she's like, you do have these skills.*

In addition to managing self-doubt, this participant also received reassurance from their supervisor around the shared trauma as well.

> *I think what was helpful for me was having my supervisor pull me aside and kind of having that breath of fresh air and reminder, like even though all of this stuff is happening around us, that we're still human and that we have our own feelings and just kinda like we had our own grounding and I feel like that was super helpful to have that be, to be pulled aside and to be like, we have this, we know what we're doing. The reassurance was helpful.*

Through supervision these participants found yet another way to connect with others in growth-fostering relationships that contained both mutual empathy and mutual empowerment. The support and reassurance that these participants received through their supervisor relationships allowed them to develop relational resilience and courage to move toward help when distressed.

Connecting Via Shared Trauma

One common theme that emerged with regard to coping with secondary traumatic stress and vicarious trauma was the importance of connection. All of the participants recognized the impact of being emotional first responders to the shootings both professionally and personally. Some preferred the connection through individual supervision or collegial relationships, while others experienced comfort in the ability to connect in larger groups of colleagues to be able to share the impact of the experience through processing or debriefing. Several participants recognized that they would have benefitted from the time to process the experience in the moment but were either too busy or not provided the opportunity to during the work day. All participants recognized the importance of mutual empathy during that time and in particular with others who could understand their experience or exhibited relational attunement.

All of the participants within the study acknowledged the idea of shared trauma and the value of mutual empathy with those who understood their experiences from a similar lens either through informal connection with colleagues or through formal avenues of supervision. Eight of the 12 participants were either employed at their school districts at the time of the shooting or lived within the community. Four of the participants were hired in the immediate aftermath and did not live in the community; however, they focused on "embedding" themselves within the school community so they could be of most help to the students and staff. The challenges of response and recovery brought cohesion to the response teams in the schools. The loss and grief that the community felt was a shared trauma for everyone. One participant summed up the magnitude of the impact by stating:

I don't know anyone that wasn't impacted by at least like one degree of separation.

The idea of connection again emerged when discussing the impact of the shootings not only with the participants, but the students, impacted families, and community members. Each connected

with each other in their own unique ways and each with the desire to connect with someone who they perceived understood their experience through relational attunement.

Social Workers Connecting with Other Helping Professionals

As previously noted, connection was an important theme that emerged from the idea of managing secondary traumatic stress and vicarious trauma. Some of the participants mentioned that the chaos and intensity of the initial response was challenging especially collaborating with other disciplines, but the shared trauma eventually brought cohesion among the teams. Two participants within the same district noticed the differences in the training of the different disciplines and expressed concern that their approach was different from social work. There was some initial tension between the disciplines reported and the space was described as uncomfortable. Most of these tensions were described as concern in their knowledge of trauma treatment as well as not coming from a strengths-based perspective which are hallmarks of social work practice.

> *There was a lot of tension and it wasn't a comfortable time. It was very tense. I'll tell you what, we became such a tight team, but it didn't start that way. It just kind of grew that way. We come from different perspectives, so people are looking at things differently.*

Despite this initial tension, these participants described that over time there was cohesion that developed within the team, almost a “we are in this together” attitude. The shared trauma of the shooting and the demands of the response allowed for professional and personal connection. This participant continued to describe the evolution of the interdisciplinary group cohesion:

> *They stuck together, and I think that that actually created the glue. They became very, very close and very protective of each other. It really was amazing.*

Although participants experienced tension initially from the professional differences, the mutual empathy and authenticity they received through connection with each other ultimately allowed for the establishment of growth-fostering relationships with each other. Another participant at this school also described the interdisciplinary collaboration as it strengthened:

> *One time I had eight people and I pulled in a second therapist so we could co-facilitate the process because so much had been going on and eight (people) is a lot to process. She's not a clinical social worker, but that didn't matter because of the camaraderie we had for each other to do, to do whatever we could at that time. It pulled us all together.*

The shared objectives and challenges of responding to the students under the intensity and pressure of a crisis response setting allowed different disciplines to provide each other professional and eventual personal support.

Participants at other districts expressed no concerns about other disciplines; however, this could be attributed to either their level of exposure to other disciplines or the relationships that were formed with these disciplines prior to the response. What was common among all the participants was that shared trauma of the shootings and the demands of the response efforts formed strong clinical teams. About half of the participants discussed how they still kept in contact personally with those other professionals despite being relocated to other schools or those professionals leaving the district. The relationships formed by these shared experiences have endured.

Social Workers Facilitating Connections Among Students

The connections that were created among clinicians were also observed among students with other students. Participants from across the different school districts reported that they observed many students also demonstrated a desire for connection with each other during both

the response and recovery periods. Impact varied on students depending on their zone of proximity to the shooting; however, regardless of where they fell within these zones many students gravitated toward connection with each other. A few participants mentioned that group work was very successful; however, those groups with a predetermined curriculum or topic seemed less appealing to students, keeping their attendance low. Those groups that seemed most successful appeared to be less structured and more focused on organic connection among students. One participant described a group in which students just wanted to order lunch and talk to each other:

> *I actually started a group of children, uh, one boy, four girls, five girls sometimes, and we would meet and they'd wanted me, want me to get them lunch and Uber lunch and nothing was allowed on campus and I, they didn't want to be alone. I said, okay, so how about if we do it as a group? And, um, and they were of different ages, close in age, but different. Yeah, there was a child that never would come to school until it was like group time and she'd come to school.*

A participant from another district who also supported older students in the middle to high school range concurred that their students also displayed a desire to connect with each other more than adults.

> *They had us go to the school, and we were there, just available to try to meet with students and talk to them about what happened and how they're feeling, and they were just not really sharing much. But when you would see them with each other, with their peers, it was just a different connection because they can relate to each other, they're the same age group, they go to that school, they're students there, and I thought I was getting the sensation that they were connecting better with each other than with the rest of us*

> *that were there supporting. That was my impression. It was organically. They just wanted to be with each other and connect with each other. They were utilizing that space to be with each other, but it wasn't because we were trying to run groups or connecting with them, it was, "I just want to be with my peers and talk to them and be there for them and be there with each other and talk to each other, and that's it." And there were some students that did benefit from connecting with an adult, but the majority of them, all they wanted to do was be with each other.*

This participant related the students' desire to connect with each other as a parallel experience to what they and their colleagues felt about connection around processing experiences. They explained the desire to connect with those who shared experiences.

> *We tend to connect with the people that we feel like we lived something through with. And that's what I felt with the students, they were like, "Yeah, I get it, you guys, adults, are here to check in on us, and if, you're here, we want to talk. But we are not getting it at the same way that we get it," and that's how I felt with my team here. I feel like admin didn't get it because they were also expecting us to check in on everybody, even teachers, but I felt like the rest of my staff that was put in the same position as I was, and they lived it not the same way, but we went through it when it was all happening, that I felt like I had a better connection and a better understanding with them, and I felt the most comfortable being with them and checking in with them.*

Another participant from the same district who supported elementary students also observed that group work was an avenue for mutual empathy so students heard that they were not alone in their feelings.

> *And then we also did a lot of group interventions, we did a lot of restorative circles and things like that, to just kind of help students together process their feelings, and realize they're not alone in the way that they're feeling, and it's okay to have feelings about this, and how can we help support each other through this difficult process?*

An interesting phenomenon was also mentioned by two of the participants each from a different district – that students from two of the different school districts had made outreach to each other to provide support as well as social advocacy for gun safety with each other. The shared trauma from the commonality of violence brought students who lived in different parts of the country in connection and relationship with one another. The mutual empathy they experienced not only allowed for relational resilience, but mutual empowerment in which they moved forward with common advocacy as a form of healing.

Social Workers Facilitating Parental Support

Similar to students, the parental response was determined greatly by their zone of proximity or impact of the shootings. What was noticed specifically in one district was that those families most impacted – they had a loved one killed or injured – also demonstrated the inclination to connect with someone they perceived to have an understanding of their experience. One participant described how a group for most impacted families that was initially created for logistical information, district communication, and official support morphed into a processing group once district officials ceased attending. This group was not initially formed as a processing group, but it organically evolved into the sharing of experiences, the details of the shooting, and how it impacted their respective families. These family members who had been profoundly impacted by the shooting sought comfort in others who shared this trauma and grief.

Social Workers Facilitating School District Connections

A participant from each district mentioned that they were aware of how each of the schools had connected with each other in the immediate aftermath of the shootings to provide support and guidance to one another. Apparently reports indicated that Columbine High School initiated this connection and it has become a tragic tradition that previously impacted schools make outreach to those schools who have "joined the club that no one wants to be part of." This was a term that one of the participants used to describe the shared trauma among the different impacted schools. One participant stated:

> *We spoke with the principal from Columbine…..unfortunately there's been too many of these incidents now, there is some expertise out there on how you support a school community after gun violence. It's out there now, you just have to reach out to people. You don't have to do it alone. Yeah. It's probably my biggest lesson.*

One of the participants interviewed discussed how their school recently made outreach to officials at Oxford High School, the most recent site of mass targeted gun violence at the time of this data collection, to offer guidance and support. Another participant at a different district also mentioned how they of their own accord sent an email of support to the social worker at Oxford High School.

> *I sent an email to the social worker at Oxford. I didn't ever expect to hear anything, but my email included, "Be sure to take care of yourself and be sure that you have some solid support around you." I said something about preparing yourself to listen and hear students when they come in.*

The participant added that they did not expect a reply because she remembered she barely had time to check her email in the early days of the aftermath of the shooting. The participant reflected that they felt the urge to reach out likely because they were activated by hearing of

another shooting and having a sense of what the Oxford High School support professionals maybe experiencing during this time.

Social Media's Impact on Connection

Another vehicle of connection used within the school communities was social media. The topic of social media was a very polarizing topic among participants as far as their perception of the benefit over the risk of it. Several participants in different school districts mentioned that social media was helpful in allowing others to connect with each other offering support and sympathy. All participants mentioned that the outpouring of support from the general public was at times overwhelming. Much of this support was facilitated by the delivery of information through both the media and social media. From stuffed animals, to financial contributions to services offered – much of this was initiated through connection through social media. For some communities, social media served as a means of communication for vigils, funerals, and memorials. One participant explained:

> *It's a vehicle for communication. I'm sure that there was communication around like services and vigils and, and so those are, those are helpful ways to use social media, to communicate out to lots of people without having to make like 50 phone calls. I think back to like, that's how, that's, how it happened in the, in the old days.*

This same participant was also able to identify how it connected and mobilized parents from different schools who were interested in social advocacy around gun safety.

> *I think about the post-traumatic growth for so many of the parents that have become advocates around gun rights or safe schools and that has also been very driven on social media.*

This participant also highlighted that social media can be a connector for those who did not necessarily want to interact with others around trauma and grief. They also mentioned risks of social media through well-intentioned but insensitive communication as well as conspiracy theorists who have claimed that several of the shootings within 2010–2020 have been hoaxes.

> *I think social media can be really helpful. You know, the recovery groups, there's the trauma, the Columbine, the rebel Facebook groups that a lot of trauma survivors go to hear how other people recovered or move toward recovery. But, and I think you can, you can just watch and read and not necessarily have to participate in it and it's safe. Because you're at home. You don't have to, you know, go to a group. I think it can be used in a positive way, but it can also be extremely triggering because people say and do things on social media that can be very insensitive to people who are in early recovery or also, you know, the conspiracy theorists that also retraumatized many people, people, you know, that, I mean, that's a real thing.*

Many others expressed reservations about social media's negative influence. Several participants across two impacted districts discussed how social media became a vehicle for anger and exacerbated division among their communities – directed both at the respective school districts as well as at political opinions about gun safety. Social media also at times caused confusion and conjecture with the dissemination of rumors and false information. Participants in these same districts also introduced the idea of how social media can be retraumatizing especially to students who had pre-existing mental health conditions. One participant mentioned that students posting videos and comments on social media during or in the immediate aftermath of the shooting allowed real-time access.

> *What was happening- it was caught on tape and streamed to students in other parts of the building or other parts of the campus via social media. I am curious of that impact because they were exposed to something in real time or even 30 minutes later. But they were right there or let's say the next building, if it wasn't caught on tape, they wouldn't have had that ability to process through it. And it's not like they were watching it one time, they're watching it over and over and over to really try to figure out what was happening. So, it increases the anxiety.*

Another participant had similar concerns about the potential retraumatization through use of social media and encouraged parents to limit their children's exposure to social media and images through other media outlets.

> *I think back to 9/11, it was on for days, we just watched the towers fall time and time again. And I think, you know, you watch the kids running out of Sandy hook or the kids running out of Columbine with their hands on their head. Like, I can think of the images that get looped a lot. And those get looped on social media now and also kids have so much more access to social media. I was really advising about restricting access to your kid. Like one of the things for kids, is to buffer them from this madness. Right. And buffer them from the news coverage.*

Social media was the topic that elicited some of the strongest responses from participants. Although several articulated the benefit of social media both in communication of details and as avenues of support for those who preferred support virtually, the majority of participants expressed reservations over the risk of social media especially to students. Several participants indicated that especially during the weeks and months following the shooting, that they did not access social media in order to protect their own well-being. They also frequently recommended

to students and their parents that social media engagement be limited. This highlighted the idea that both connection and acute disconnection are utilized as coping mechanisms in the response and recovery process.

Gaining Knowledge About Trauma

In addition to exploration of ways in which social workers were able to navigate providing support to others and maintaining their own well-being, this study aimed at understanding what they learned from their experiences and how that may benefit other school social workers or social workers contracted in the aftermath of targeted gun violence in schools. Several dominant codes were identified from the interviews and all of them pertained specifically around the knowledge and treatment of trauma. The first and most prominent was the understanding of coping with trauma and how the Zones of Sadness can often determine an individual's response to trauma. Also, therapeutic intervention often needs to be continued or restarted based on developmental progression and activating events. One participant stated that "trauma is not linear". Finally, the findings will note what social workers learned about trauma with regard to responding to both parents and staff in the aftermath of these tragedies.

Understanding the Coping of Trauma

Through discussions about the crisis response and recovery efforts, participants shared what they knew about trauma prior to the shooting and what they learned about coping with trauma from their experiences. A common observation among all participants was that responses from students and faculty/staff varied by the Zone of Sadness (Strozier, 2011) and their individual protective factors. Developmental factors were also recognized as critical to providing support to students. Participants acknowledged the loss of safety in the school both for students and themselves as well as the importance of leadership consulting with trauma experts. Finally,

participants shared their experiences providing support to families and staff and what best practices they discovered in the process.

Zones of Impact

Zones of sadness is not a new concept originating from this study, rather it was coined by Strozier (2011) in a post 9/11 study describing how proximity and relationship to the trauma event often influences the severity of response. As previously noted this concept accurately describes the impact of physical and emotional proximity to the shooting, but fails to capture the horror and pervasive nature of this type of trauma. Feedback from all of the participants in this study endorsed the zones' relevance regarding proximity in all of their response efforts across the three school districts. Trauma responses varied in students and faculty based on their physical proximity to the shooting, their relationship with the victims or the injured, and their individual protective factors, such as close relationships and stable homelives, that assisted with mitigation of the response. One participant used the analogy of a pebble being thrown in the water and the ripples on the water to signify the layers of impacted individuals.

> *I look at it as I'm throwing a stone in the water and the stone is the tragedy. And then the first ripple is everyone I loved who was murdered in the building. The second ripple was everyone who was injured in the building. Then there were all the people that watched it happen and still got out of the building. I think there's more to do in the other ripples because it's not just the people that were shot and murdered. It was everyone who witnessed it. It was everybody else on campus. It was everybody in the community or in the schools that were on lockdown. There were all of these ripples.*

This participant also mentioned the magnitude of the impact of the shooting on everyone in the community to varying degrees. Another participant from the same district expanded upon this

mentioning zones of sadness not only pertained to the trauma that students and staff experienced, but also the guilt and sadness students who were not in the building experienced in the aftermath.

> *There was a level of guilt that the children presented with who were not in the building, but knew someone who was, like, you know," it should have been me. Maybe I could have, I could have helped". There was a lot of guilt, you know, it's like distorted guilt didn't really make sense. So, they, they couldn't really put their own heads around why they were feeling guilty, not being there.*

A third social worker from this district felt like the student response was unique based off not only their exposure, but their protective factors and any pre-existing mental health concerns.

> *I think the responses were very unique. Some people who were nowhere near the whole experience were incredibly impacted. Whereas others who were very close by, in proximity to the shooting, I was amazed at how well they were coping. Like when we did our check-ins, some kids just have more support than others. Those with support fared quite well and some without any really struggles. Some, I wouldn't say all, but some, without a doubt, it had a shocking impact. I was surprised by some of it. I mean, it's not to say that there weren't some kids who have an amazing support system at home, but they still suffered greatly and they were in the building. So, you know, it was, everybody was very unique in their response*

A participant from another district concurred that many students within the building or who had relationships to those killed or injured had intense responses, but also agreed that some students who were not within proximity still experienced significant distress.

> *Most of the ones that needed the most support was either really involved in the day or very close in proximity. The ones that are less are the ones that were either not on*

campus yet, or like driving to campus were in the far, far parts of campus - I do have two students who were not on campus during the time, but had a strong emotional response to this event.

A participant from the third impacted school district summed up their experiences and observations about the zones of sadness.

Where people were in the building absolutely impacts the level of trauma that they experienced, not necessarily the grief they experienced. Right. Because you have both, you have traumatic grief and then you have the trauma of the experience. Yeah. So, so the trauma of the violence of what happened is one thing, but then you also have the people who lost their classmates, the people who lost their best friends, the people who lost their swimming buddies, like it just like, there's all that loss, but it gets sort of mixed up with the trauma. And it's very different depending upon where, where someone, so someone was in the building, what they saw, what they smell, what they heard. Some people were in the back of the building and didn't know what happened. Like they, they didn't experience the trauma at all. The connections that people have - that can be really helpful, protective factors. What's their support system, like, how close are they to their significant other, do they have a significant other, do they have kids in the school system? Well, that would not be a protective factor as much, more of a complication because there were teachers that had kids in the building. So, you know, their response, how did you know that is kind of different where they're worried about their kids being, you know, hurt or so, but they're definitely a protective factor. So, the, the way that somebody uses their support system, how well they are able to share. Are they willing to get therapy? You know, I mean, one of the things that happened over time is that everybody was in

therapy. I think it was just the intensity of the trauma. I mean, even if you didn't know anybody, you were still traumatized at what happened.

This participant also highlighted the difference between trauma and grief noticing that some students and faculty who did not have exposure to the shooting, or who were not connected to the those directly impacted, experienced a sense of grief rather than trauma.

Protective Factors

All of the participants identified protective factors that assisted students with managing their trauma and grief. Most notable was the support of family and friends. All of the participants were able to relate this back to attachment theory and the benefit of positive relational figures in their life prior and after the shootings. One participant specifically mentioned the influence of a strong parental figure in a student's life.

It was all related to attachment if they had one strong parental figure that was just there for them and unconditionally love them, no matter what.

This participant explained students with positive growth-fostering relationships were still impacted; however, they often were more relationally resilient, employed coping skills, and were less likely to have long-term impairment in functioning.

Another participant shared that a student they worked with who was exposed to the trauma of being in the proximity of the shooting did not exhibit impairment in functioning and was able to communicate with their parents their feelings about what they witnessed.

I think that the student was resilient. I think that the parents had raised them to be, you know, with a good attitude about themselves and feel supported and all those resiliency factors. And the parents shared with me that the student had always been one of those people who would let things roll off their back. Like nothing was a major impact, unless

> *their phone was taken away. They seem to handle everything in stride and it was a matter of their temperament. And so that was another thing that I said - I don't know how as things progress, this is, it was a short time and this could be shock. You could be looking at shock and it could all change, but the fact that they're okay talking with you about it, and they're okay with eating and they're okay with sleeping and they're, you know, wanting to hang around their friends. It is possible, not everybody suffers from PTSD after an event like this.*

They explained that this participant had a stable home life with a supportive family; however, they felt that the student's personality also played a factor in their resiliency. This participant described personality in terms similar to RCT's relational courage – the ability to move through fear by seeking connection with others. This participant also introduced the idea that exposure to a traumatic event did not equate development of Post-Traumatic Stress Disorder (PTSD).

Developmental Factors

Another factor that was mentioned by several participants in student response was their developmental stage. Participants' school assignments spanned across all grade ranges from elementary through high school. A participant that provided support to elementary school students indicated they were always thoughtful to their use of language so that it was age appropriate, but also the students' level of exposure and their understanding of concepts such as death. One participant shared that other students would often seek their guidance in how to communicate with their friends who were most impacted by the shooting. This participant was teaching their students emotional intelligence and empathic communication.

> *These kids that would come to me and ask me, "How do I show my friend that I care about them? How do I help them? What am I supposed to say?" Trying to navigate that and trying to figure out what to tell them.*

Another participant from a different district who also worked with elementary school students discussed how students can also experience different distress as they move through age-related milestones such as elementary to middle school or middle to high school. The participant explained that the nature of trauma work is that often treatment needs to be continued at different stages within the student's life.

> *I think that's the other thing that we realized about time is that you might have to redo the work that you think you already did. So, if you kind of stabilized and did some really great trauma work with a nine-year-old, who's now in transitioning out of the middle school and getting triggered all over again, you're going to have to do that work again. So, I do think that kind of developmental lens is important when you're talking about working and healing with the school community over the years.*

This participant endorsed the idea that treatment often needs to be continuing or restarted when reactivation of symptoms occurs.

Loss of Sense of Safety

Another observation that several participants from two different districts expressed was the sense of safety that was lost within the school setting for both their students and themselves. One participant explained that students they worked with expressed the desire for more safety measures within the school community as a precaution.

> *Even the kids would question the security because they didn't change that much. There were no metal detectors, all the things that they would hope for, the children would hope*

> *for, checking a bag. So, they were very suspicious and just concerned. They didn't want to walk by the building, things like that. These kids were very traumatized and they're coming back to the place that they were traumatized.*

This participant also explained that some of their students were faced with a visible reminder of the trauma on a daily basis which heightened their anxiety about their own safety. A participant from a different district also noticed the same concern with the students they worked with as well as their own concern about possible future danger.

> *I remember specifically at this school site a couple students, when we were checking in with them, they would say to us, "Well, how do I know it's not the principal the one that's the shooter, and he has a key to every room?" So, it was a couple students that were saying that to a couple of us, and I was like, "You know what? That's true." That is true. So, that's something that, afterwards, I was like, "How do I know it's not one of the staff members that has a key?" It wasn't even my direct trauma, it was just because I was hearing it from these kids. So, now, I'm like, "I don't know if it's going to be you," and I still think about that to this day because some of the staff, they have master keys and they can go into any room. How do I know it's not them? Because we've seen other shootings where it's not a student, it's someone who works there or the partner of someone who works there. So, it just has you seeing things a different way and thinking about things. And I was like, "Wow, they're so smart, I never even thought about that." In my mind, it's just like, "It's a student," but I never thought it could be a staff member that has access to going inside the classrooms until they started talking about it, so now I think about it and a couple of us think about it.*

Phases of Emotional Response

About half of the participants mentioned the phases of emotional response and two of them specifically referenced it as the Disaster Life Cycle (Benedek & Fullerton, 2007; Hobfoll, 2007). It was mentioned that certain emotional responses were common in specific phases and that interventions are often selected based on the phase of the emotional response the individual is presenting with at the moment. When asked what would be important for social workers to be knowledgeable about if they were part of a response team in schools, one participant indicated understanding the different stages was a key component.

> *I would like everyone to know the phases of emotional response in disasters, there's this disaster life cycle slide that I've used. It talks about the impact and the kind of heroicism that you see and like the honeymoon period where we're all together, we're all one, we're all connected.*

They continued to explain the customary timeline associated with the different phases of response and treatment.

> *So typically, they say that folks who have experienced some type of a trauma, and we'll say a trauma in a school setting, or any type of a trauma. It's like 30 to 45 days of kind of trauma symptoms, that acute phase. And then you kind of transition to hopefully people return to their previous level of functioning and that they may have to do some work based on that. Some therapy, some work. And I guess I would really think about disaster mental health for the first 30 to 45 days. And then kind of then thinking about kind of other levels of trauma therapy and trauma work after that.*

This participant who was both in a direct practice and leadership role explained the difference in the stages in an individual as well as more of a community systems-based perspective.

Another participant from a different school district described the stages of crisis and recovery they observed:

> *There are multiple layers to it. I felt like there was certainly, you know, an in the moment response, there was an immediately thereafter response. And then there was, you know, I think like, not just the treatment response, but there was something in between that, to where people were still trying to stabilize and still trying to find a healthy baseline. They were still trying to get out of crisis mode.*

This participant did not refer to the phases by name, but was able to describe the presentations of individuals as they moved through the phases from crisis to recovery. Another participant from the same district explained how selection of interventions should be determined by the client's presentation rather than a predetermined set of time. They continued by explaining that the transition from crisis intervention to more trauma-focused therapy could not be predicted by a disaster model because for some the impact of the trauma was so significant.

> *You can't assume that they're ready for therapy. Wow. That's a big lie. Therapy, like the old-fashioned therapy. You, you, you find a good therapist, a psychiatrist and you make an appointment, you work out your problems. What I learned is that they couldn't identify what the problem was because the experience was too profound. It would be like six weeks, sometimes eight weeks for some who weren't, um, didn't know anyone at the location, didn't have a connection with any of those teachers, but still felt grief.*

Seeking Guidance of Experts

Another key area of gaining knowledge about trauma that emerged was the importance of seeking guidance from national experts. Although some of the participants had trauma training, there were aspects of responding to targeted gun violence in schools that were new to even these

trained social workers. All three districts sought guidance from national experts of crisis response and recovery in school. One of these participants was in a supervisory role and they not only provided direct services, but were also an integral part of coordination of the response. The participant described that after a long day at the school, they would often speak with a national expert in the evening to review and plan the ongoing response.

> *I ended up doing a lot of consultation with a national expert from the National Child Traumatic Stress Network, disaster response network. It's an actual team. And I talked to their coordinator regularly.*

A participant from a different district whose focus was on direct practice with students recalled how their district brought in a national expert to provide them education as well as assist with facilitation of parent forums within the community. It was also mentioned by those participants in leadership roles that the guidance from the other schools in the country that had experienced similar targeted gun violence was invaluable. In particular several indicated that the guidance on community interventions was helpful as the violence not only impacted the specific school communities, but the larger geographic communities.

A Traumatized Community

Several participants across the three districts described the impact on their respective communities with such statements as no one was left untouched or there was one degree of separation – everyone knew someone in some way that was impacted especially in the smaller communities. Participants witnessed their communities initially unite in their response during what one participant referred to as the "honeymoon" phase, but some later observed anger and divisiveness develop within their communities. In these communities, disagreements about available supports, memorialization, and gun safety advocacy emerged and were fueled through

social media. There was also anger toward school administration in two of the districts both in their coordination of response efforts and the communication of these efforts as well as blame for the inability to prevent the shooting. One participant shared:

> *Communication is the number one typical issue of traumatized systems and was definitely an issue here. School districts are specially wanting to make sure that everything like it goes through so many tiers and often times nothing is said because they want to make sure they say the right thing. Well saying nothing is worse.*

There were similarities and differences in the community-based response among these three individual school districts; however, detailed information will not be provided in an attempt to protect confidentiality. Every participant in their own way expressed the idea that their communities will never be the same. All three of the school communities offered various levels of support including either psychoeducational forums or counseling services to families and community members, even those without direct connection to the schools. There was a realization that this violence transcended the borders of the school property.

Trauma Is Not Linear or Ever Finished

When discussing trauma experienced in their schools as a result of the shootings, all participants mentioned that their experience was the work was never complete – there was never a finish line. One participant described it as:

> *It is not a sprint, it is a marathon.*

They explained that often the work was ongoing because of reminders and time markers. Another participant in the same district explained that trauma work is not linear. Their experience has been it is an ongoing process and the work continues as students, staff and the

community are activated by event reminders, developmental milestones, or even additional school shootings that have occurred.

Time, Additional Shootings, and Sensory Reminders

Participants across all three districts mentioned that passage of time reminders could often reactivate symptoms of both grief and trauma within the community. The yearly observances of the date the shooting occurred and the memorials that often occur during that time can be dysregulating for some. In addition, school drills, unexpected fire alarms, helicopters, or the sounds of rescue vehicles in the distance can cause some to return to the horror of that day and weeks after the shooting. One participant shared an experience a few months after the shooting when a fire drill was not announced.

> *It was really difficult. Any car back firing….we had a fire drill and it was not a drill. We didn't know what it was. I was with students who were really frightened. It was like, Nobody's telling us and I felt that. I felt like, Okay, they've told us to leave our rooms and go out there, but there was no other information. That was maybe two months after the shooting and students were feeling that, but I recognized that as well. I didn't have my phone. We just left. It was like, Okay. The phone's going to be on me from now on, because if I need to contact somebody or ... so I think that that was one thing. I think sirens, I still do that a little bit with sirens. If I know they're going toward a school, I think about that.*

This participant shared the common auditory and visual reminders that can reactivate a similar sense of the vulnerability and fear they felt the day of the shooting. They described the feeling of hyperarousal and hypervigilance that now occurs over once-common school situations like fire drills or ambulances in front of the building.

Several other participants mentioned that with each subsequent school shooting, their communities are frequently reactivated with reminders of their own trauma and hopelessness that this violence has continued within our country.

> *So I think that there's part of it that holds true. I think then there's really these critical times in the disaster kind of phase, like anniversary responses are a real thing. And then identifying other potential triggers. There was a bomb threat called into the school one day for this poor community. And they had to evacuate and exit the school quickly, again. So, it was triggering. And I do think you have to kind of anticipate what the potential triggers could be. Anniversary responses and other kind of responses. And then obviously there were more school shootings that were happening and on the news. And kind of anticipating how that's going to kind of escalate the community, the school community that you just spent years trying to settle. So those types of things that you can't anticipate and not all the same in time, but you do have to then respond to.*

Another participant who responded to the same school district equated the subsequent shootings and the shooting at Oxford High School as "tearing a scab of your healing". They continued:

> *With every shooting people relive what happened at (NAME REMOVED) it's like tearing the scab off of your healing. It really sadly it doesn't get that much easier because what you relate to, and I'm saying this as a person, as a human who also sort of vicariously, we've lived through this trauma myself you know, how hard the path to healing is. And when they publicize five people are killed. Subsequently you sort of understand how devastated that community is in a, in a way that is really hard to explain.*

This participant referred to the idea of mutual empathy as they described the connection they felt to professionals whom they have never met before, but with whom they now shared a similar

experience. This participant also shared that around the time of year their shooting occurred, people in the community often experience sensory reminders such as feeling dysregulated when the weather is similar to the day the shooting took place. The participant explained it in greater detail by asking this researcher what they think of and how they feel on a beautiful clear sunny day in early September – specifically, did it contain reminders of the day of 9/11, a collective trauma for the country. The participant explained this is an atmospheric trigger, a sensory reminder of a collective trauma. They explained it is similar in their community in the month the shooting occurred when the weather mirrors the day the tragedy occurred.

Responding to Parents and Staff/Teachers

Response to parents and staff/teachers emerged as its own separate code within the Gaining Knowledge About Trauma theme as the experiences and information learned was distinctly different than the response to students. Many participants noticed that the teachers and staff struggled in their schools despite supports offered by the district. It was reported that for two school districts teachers were expected to participate in trainings and resume classroom learning a few days after the tragedies. One participant surmised that administration likely assumed because teachers were adults that they could manage their response better. Several other participants mentioned staff like custodians, bus drivers, or cafeteria personnel who were also distraught and were frequently overlooked when it came to supports. With regard to supporting parents, participants learned the importance of communication and the importance of providing support to both those families who had loved ones murdered and those who were injured in the shootings. Specifically, they distinguished between the potential response and supports that each individual group experienced in response to the trauma.

Teachers and Staff

A majority of participants reported that they had the opportunity to support and provide guidance to teachers in the aftermath of the shooting. Several of the participants mentioned different Zones of Sadness for teachers: those who were in the building at the time, witnessed the shooting, were injured during the shooting, or were in other buildings at the time but had loved ones within the impacted buildings or schools. In a continued effort to maintain confidentiality, specific details of these experiences will not be shared in the findings. These stories did reinforce that the zones of sadness was applicable to not only students, but also the teachers and staff within the school. Those who witnessed or were injured were significantly impacted and required ongoing supports from both the participants as well as outside providers. In addition, those who had loved ones in the impacted buildings or schools sought crisis intervention from participants. One participant shared how teachers who had children in other school locations were unable to leave to check if their own children were safe.

> *So the impact of that on them too, not just knowing a kid and working with a kid who was there and who was actually a victim, but the trauma of having their own kids that we're there and not knowing where they are or how they are, and not being able to leave and go get them, and pick them up and make sure they're safe, and then not having that next day to spend with them and know that they're okay, and have that time to do that, I think really it took away from a lot of teachers.*

The participant explained the sense of helplessness some teachers expressed with their loved ones in the impacted building and their inability to leave their own school building to ensure their safety. Although these teachers were not in the building in which the shooting occurred, their indirect exposure by having a loved one in potential harm's way had lasting traumatic

impact. Another participant shared how they supported staff during the shooting while the other buildings were on lockdown.

> *The day of the shooting, I wasn't specifically at the school where the shooting happened, that's not my assigned school; however, they put all the schools in our district in lockdown. I think the biggest part that I played was in being there for the staff… just because of where I happened to be when the lockdown happened, that I happened to be in the front office with all the secretaries, the counselors, all the counseling interns, and then we were dealing a lot with parents trying to come in and take their students out. So, I think my clinical skills specifically with the staff and with the parents and organizing all the pickup, I think that that was very valuable, having the type of training and the types of hats that I can wear as an MSW.*

This participant shared how they used their clinical skills to offer support to coworkers who experienced anxiety and panic during the lockdown. They also used their own trauma knowledge to remain present and regulate their own response.

It was reported by several participants that some teachers were experiencing difficulty communicating with their students and resuming educational instruction a few days to a few weeks after such a horrific tragedy occurred. One participant described the following:

> *You had to be back in the classroom just days later in my school, people were saying, I need a script to know how to introduce myself, to start my class. How am I going to teach math? And, you know, teachers like curriculums, right? So, they'd like to have a curriculum. There's not a curriculum. There probably should be some kind of curriculum for staff upon the return, after a major disaster. But how do you sort of get back on the horse again?*

This participant described the teachers' difficulty resuming normal educational learning after such significant violence occurred within their district. Some teachers struggled with the shared trauma while others were uncertain how to comfort and assist their students with resumption of normal school activities. Two additional participants experienced the same concern from teachers around communication with their students and as a result they developed talking points and resources for their teachers to use when they returned to the classroom.

> *There were so many teachers who have students who go to (NAME REMOVED), so many of our teachers live in the community. So, on that day and the day after, before we were pulled to go to (School Name), I had a lot of teachers in here who just needed to sit or that were scared about, "What am I going to say to my kids now? How do I do this, because my kids are terrified and horrified and sad and angry and all of those things. Their own children who were students at (School Name) and were able to talk about, "Am I doing a good job? What more could I do? How do I help this?"? Then, giving resources to teachers for their own mental health care. We put together, before we came back, it's not really a packet. I think it was just a couple sheets of paper, but things that you could say, "If these questions were asked this, you could mention this. These are websites that you can look at about how to talk to students after a tragedy." We tried to do a little bit of research to give them some support for them in their own classrooms, and to recognize some of the things that may be symptoms of some anxiety or stress. It's a script and then some supports that we could offer to students.*

Several participants noticed that their faculty and staff especially those who were very engaged in the response and recovery were often not functioning as well as they presented to others.

> *Depending upon where the people, how exposed they were to the tragedy and how, and their own psychological makeup, I mean, there were people who were in a fog for months afterwards. I mean, they may have been coming to work, but they weren't really functioning, but then the whole system wasn't really functioning.*

Although all teachers across the three districts were offered emotional support resources and some offered guidance in how to support their students, many participants offered stories of how many teachers struggled in their day-to-day functioning within the classroom for weeks and months after the shootings. Several participants mentioned that some teachers appeared to be functioning and engaged in the response process, but later realized those coworkers utilized busyness as a form of maladaptive coping. About half of the participants mentioned that ongoing supports were offered to students, but they felt it was assumed that adults would be able "to pick themselves up by their bootstraps" and return to normative functioning more quickly.

Although teachers from all districts were offered supports, some participants mentioned concern about the lack of support for staff within the schools. One participant mentioned the custodians and that cafeteria employees that work directly exposed to the violence or experienced the aftermath of the shootings with distraught students running to them for assistance. Another participant shared the sense of loss that some school bus drivers must have felt when the student or students they had driven to school for years are no longer on the bus. These participants shared the concern that many of the staff, who had experienced direct or indirect exposure to the trauma, had been overlooked with regard to access to supports.

Providing Support to Families Not Directly Impacted

While only a few of the participants supported the most impacted families (those with loved ones killed or injured), all of the participants worked with other families as a result of

providing services to the students. Participants mentioned in the days and weeks after the shooting, it was not uncommon for parents to seek guidance from the participants regarding what to expect regarding trauma symptoms and how they could best help their children. One participant commented that many of the parents were in shock that this type of violence happened in their community and expressed the fear that their children were not safe at school. One participant who was in a supervisory role spoke to the importance of giving parents psychoeducation as a tool.

> *I do think follow up is really important for people who have experienced a community wide event and psychoeducation around what distress might look like, what you can expect in the coming days, what you can expect for your kids in the coming days. I think about parents who said, "How soon should I send my child back to school?" And I'm like, "As soon as possible, get them back into their routines." So, like around psycho-education, although I do think that that's part of kind of individual and family work, the kind of psycho ed piece, I definitely know it's part of kind of community wide support. So, like holding parent forums, holding parent spaces, maybe having an agenda, but having it also be so driven by the parents. That's what I see happening when you're responding to a community that is different than responding to individuals and families.*

A participant from a different district mentioned that their district hosted a national expert on school crisis to provide education during a parent forum. All of the districts appeared to offer forums for parents as well as walk-in centers in which parents and children received in-the-moment support in the immediate aftermath. Participants also assisted these families with linkages to outside mental health providers for ongoing long-term support.

Building Relationships with Families Most Impacted

Two participants from two different districts reported experiences assisting with support to the families most impacted by the shootings – those who had loved ones that were killed or injured. The first participant provided support to some of the families on a short-term basis. They recalled the first day of the response in which they were involved with parental notification. They recalled the intensity of the scene in which words were not enough, and remembered something one of their former professors had mentioned to them about effective crisis response.

> *I remember one of the professors saying, you know, if you have to touch someone in this work, it's because you don't know what to say. And I was like, I had such a reaction. And I'm like, you've never sat with a parent whose child was brutally murdered in their classroom. The only thing was to reach out and touch that person, to just put your hand on their arm as they're sobbing.*

This participant discussed the emotional impact of working with these families and the experience of mutual empathy. The distinction between theory and practical application was highlighted as some experiences required more authenticity than just active listening and reflective statements. It required a skilled social worker to navigate the ability to be truly authentic to connect with families experiencing this depth of pain while also maintaining professional boundaries.

The second participant was not involved in parental notification, but through long-term connection through ongoing support services, testified to the depth of pain for the families. The participant shared how impactful hearing the experiences of students and families was with regard to the details of the shooting and their experience of STS as a result of holding space for them. The participant explained that holding space was needed to foster therapeutic

relationships. Given the level of trauma and loss that most impacted families experienced, the participant felt it was critical to establish trust. In addition to holding space, this participant also referenced the benefit of meeting families' concrete needs as a way of establishing trust.

Another participant described meeting concrete needs as "practical support".

> *Practical support, like figuring out what people need practically. I think about the incident and there were parents who wanted their kid's artwork. How you get that, how do you arrange to get that for parents.*

The second participant concurred regarding the importance of "practical support" and described how they attempted to support through facilitation whether it be arranging academic tutoring for those students who were injured or picking up textbooks for the next school year to allow them not to be on school grounds. This participant indicated that the work was unique to each family and often the needs did not follow the hours of the typical school day requiring time on nights and weekends.

In addition to meeting concrete needs, both participants mentioned the importance of providing choices and control to these families. They both explained that during such tragedies, the impacted families feel a loss of control and a deep sense of grief, and that "giving them choices is the least that can be done for them". One of these participants explained that when they were communicating they always gave the families various choices and then allowed them to decide what they preferred. They indicated that through meeting concrete needs and providing choices, it allowed for increased engagement with these families.

This participant also discussed the importance of ongoing communication noting that often during tragedies of this magnitude there can be systemic breakdown in communication and that school systems are some of the biggest systems. They explained:

> *Communication is the number one typical issue of traumatized systems and was definitely an issue here. School districts are specially wanting to make sure that everything like goes through so many tiers and often times nothing is said because they want to make sure they say the right thing. Well saying nothing is worse.*

The participant explained that often times there are legal concerns which slows down communication to the most impacted families. This participant also shared that they had become the primary source of communication with the families and their school district around logistical needs such as textbooks and attendance at school events as well as assuming the role of emotional translator to describe families' concerns in language the district could comprehend.

> *I handle all communication to families. I'm the first point of contact that families reach out to. So, in many cases, any communication that comes from the district comes through me as the point of contact. I arrange any meetings that the families are requesting or the district is requesting, I participate in those meetings, I support students, whether they're injured or their siblings on campus. I am a part of the preparation process for helping the school understand the student's story and the family story. I'm an additional resource to look at when there are challenges - what are the needs of that student and how we can accommodate those needs.*

Support to the most impacted families in another district also developed into a single point of contact as well in which this individual served as the mode of communication so the district could understand the needs of these families. A participant who responded to this district explained how this single point of contact for the families developed.

> *Initially there was not someone who dealt with just the families. It was created a couple, literally, probably a year and a half later because the person who was working with some*

> *of the families in her school did such a great job with the families that it became apparent that the families really sort of needed somebody, a point person in the schools. But that was sort of missed in the beginning. At that point, each school was dealing with their students and family, if they had siblings.*

The participant continued by indicating they believed the "family liaison role" as they labeled it was not only important for communication, but also assisted with support for those siblings of those students either killed or injured. Siblings of the victims were often matriculating in the school buildings where the shooting occurred or in other school sites which contained memorials and reminders of their loss. Many of these students' academic performances were impacted by the grief and trauma impact on their family units. The "family liaison" single point of contact allowed for monitoring and support of these siblings and those injured students who returned to eventual school attendance.

> *It wasn't based on a realization of a clinical need, as much as it was sort of a crisis management of those families, because some of those kids, the siblings weren't functioning at all. I mean, they, they weren't coming to school. They were academically falling far behind and the families were in crisis. I wish it was something that was thought about, you know, the year before, but we're just navigating like, like I remember being in a staffing meeting at the high school, with one of the siblings who was an, a, B student was failing and it was like, what's going on with this kid? What can we do to help? We had to like work on creating a plan for this. How do we get this kid back on track again? And, you know, we should have anticipated that ahead of time, not waited for the child to almost, you know, be failing out of school. Of course, she couldn't*

function in school there were all these reminders in the school where people had built memorials.

The relational theme of the power of connection can be identified again within the Gaining Knowledge About Trauma code. Participants shared experiences about what they learned from providing support to others during this time. Whether it be students, teachers, families, or the communities, relationship building and trust were critical in both the crisis response and recovery stages. Participants realized their work was ongoing and that trauma treatment is not linear. Reactivation of trauma and grief was caused by time observances, memorials, additional school shootings, or for some the sound of a siren or an unexpected school safety drill.

Preparing the School Social Worker for Crisis Response & Recovery

This study also sought to explore how participants were trained or prepared for crisis response work in schools and the skills they felt were critical in preparing future school social workers. Specifically, the question posed to participants was did they feel prepared by their MSW education and training to provide crisis intervention and trauma recovery support to students, staff, and families? A small percentage of the participants received specific trauma or school social work training through either their MSW instructional classes or post-MSW training. A majority of participants identified that their knowledge and skills were obtained either through their MSW field practicum or post-MSW practice experience. In addition to the methods in which they learned crisis response and recovery, participants shared the specific skills and interventions they found helpful in their work.

Learning Through Trainings, Field Practicum and Work Experience

When discussing the preparation for crisis response in schools, only about half of participants had classroom instruction either through their MSWs or post-MSW trainings. Five participants indicated they had either a school social work-related class or a trauma-specific class within their MSW curriculum. These participants were also required to have certain courses in order to obtain their state credential for practice in schools. Four additional participants reported that they had specific training in trauma that they obtained after their MSW either through certification or professional development trainings. These trainings were either offered by their school district or taken from their own personal interest in the subject matter.

MSW and Post-MSW Instructional Courses

Five participants mentioned that they had the opportunity to receive specific school social work-related classes through their MSW education. Of these five participants several sought additional professional development on trauma post MSW. One of these participants was subsequently trained in Trauma Focused Cognitive Behavior Therapy (TF-CBT), Psychological First Aid (PFA), and Seeking Safety. One other participant completed a school social work certification post MSW outside of the state credential that is part of some state's official certification process. Of the six additional participants who did not take specific school social work- or trauma-related courses in their MSW, one completed a university-based certificate program in trauma. The others reported that they had completed post-MSW professional development due to professional interest including TF-CBT, PFA, Cognitive Behavioral Interventions in School (CBITs), Seeking Safety, Bounce Back, and EMDR.

One participant explained the reason that they pursued additional training in trauma pertained to their specialized interest:

> *I always specialized in inner city youth so I think most of my exposure and experience has come from continuing education that I selected versus something that was required as a clinician in the community. I did a lot of continuing education and suicide assessment training in addition to other trauma focused CBT trainings.*

Although the participant was not employed at schools during that time, they recognized the prevalence of trauma within their practice setting and the need for specialized knowledge.

Another participant who also did not have school social work specific courses or certification identified their personal interest in trauma studies as their desire to pursue professional development training.

> *I feel like somehow I stumbled into it and became fascinated with how the brain could heal because there was this idea that your brain was stagnant. Of course, we went beyond the idea that at six years old, your brain is formed.*

This participant continued to explain their fascination with neuroplasticity and their desire to continue learning about trauma. They indicated that they completed training in multiple trauma-related interventions including TF-CBT, EMDR, Neurobiology of Trauma, and PFA. In addition, they reported both their post-MSW work experience in addition to their MSW field practicum experience as a youth emergency services counselor as beneficial to their skill development.

Practical Application Through Field Practicum

MSW field practicum was identified as an important contributor of crisis intervention skill development. One student captured the importance of practical application stating the following:

> *I think it (MSW coursework) provided a framework for me. I think more of the experience comes from postgraduate work and field experience within the field and obtaining my job and working in the field in those settings*

Several participants reported having the opportunity to be placed at a school site during their MSW education and reported that this experience was very helpful in giving them insight into the role of a school social worker. They indicated it gave them a perspective that classroom instruction could not provide as they referred to the importance of experiential learning. Participants explained that in particular, field practicum in a school site gave them experience with home visits, child welfare, risk assessment, de-escalation, responding to crises on a smaller scale, and navigating within a larger system.

> *My second internship, I was placed at a school so we did attendance and welfare, and then we also had our own case load where we dealt with just kids with anxiety or depression and just doing clinical work with those students as well. So, I learned my school social work through my practicum.*

Another participant described the benefit of "hands-on learning" from their school-based field practicum regarding learning crisis intervention skills.

> *I did my training in a school-based mental health clinic. And the experience that I did get in that practicum was exceptional. I wouldn't say like any classroom basis in terms of the teaching, it was hands-on teaching either in that practicum experience or in other jobs that I've worked in the fields over time.*

Several other participants mentioned although they were not placed at a school specific field practicum site for their MSW training, they had received a children-, youth-, and families-oriented field practicum.

> *At that time, the university that I attended had a relationship with (Name Removed) Schools, so you could do an internship. As one of your internships you could do that, but the internship that I took when I was in school was actually as a youth emergency services counselor. I would go out to homes where there was a crisis and they concerned about the student. We would lethality assessments. Our main goal was to go and de-escalate the situation and refer the family to services.*

This participant pointed to this early field practicum experience as giving them exposure to risk assessment and crisis management. Another participant decided to prepare for their role as a school social worker by completing a post-MSW, university-based school social work certification. The participant reported that the course work was important; however, they detailed the importance of the field practicum experience in the learning.

> *I spent my internship time in a large school in more of the lesser socioeconomic status, and so it was quite interesting. I think that's probably where I started learning about crisis intervention. There was one on one family interaction. Part of that class's work was to be within a school setting and work with families who were really struggling in different ways, getting kids to school, finding resources. It was very hands-on. I worked with all the students who were in summer school, which were students who had struggled throughout the year who were not real big fans of school in the first place. Then, in the regular semester when classes were in session, we had students who were suicidal. I don't believe that we had anybody who brought a gun or a knife or any violent things during that time, but we had a lot of students who were in crisis, either suicidal ideation or mental illness issues. I think it was pretty important because it really focused on school situations. We talked about school law. We talked about what was appropriate for*

social workers to do in a school setting that may not be in another setting, and the politics of a school and school board issues. I think the skills that we learned are pretty universal, but it was nice to put a connection between those skills and how they might be used in a school.

The details of this participant's field experience reinforced what many of the participants had shared with regard to skill development through experiential learning; however, this participant highlighted the specific benefits of a field practicum experience at a school site.

Another important component of field practicum that emerged in addition to skill development was the importance of quality field instruction. Three participants specifically mentioned supervision as an important component of learning in MSW field practicum. Two key areas identified as important were boundaries and self-awareness. Boundaries were discussed in relation to self-care during crisis response and the idea that establishing healthy boundaries can assist with management of secondary traumatic stress. One participant explained how they wished this concept had been introduced in their field practicum.

I believe that that is a much more constructive, helpful way to learn about yourself in order to know, okay, this is what my boundaries need to be. This is what my limits need to look like. I wish I had more of that pushed on me. And even like, maybe it would have been more appropriate in my practicum classes to have those professors sit and talk to you about boundaries, not just, you know, okay, what you share with the client, what you don't share with a client. I need to know about how to function in this job and not die. This is like serious business. You know, there are professionals that get to the point of having suicidal thoughts themselves that really their mental health suffers from this work. It is intense

With regard to boundary management and self-care, this participant also mentioned the importance of self-awareness in the work with clients and discussed the benefit of field tools known as process recordings or reflective learning tools.

> *When I'm sitting there doing the intervention with the client, I need to look at what's happening with that client. I need to observe what's happening for me.*

Although for many MSW students this field tool can be time consuming and tedious, this participant confirmed that for many MSW social workers the tool was crucial for reinforcing so many basic social work concepts. When discussing STS and self-care, all of the participants mentioned the importance of self-awareness in the practice of social work.

Post-MSW Employment Experience

All of the participants mentioned that their employment experience had been beneficial for their growth as a MSW professional and specifically for assisting in the preparation for their crisis and recovery work at their school site. For about half of the participants, their post-MSW employment experiences were the settings that they felt most prepared them for crisis intervention and recovery work. Several of the participants mentioned nonschool-related employment experiences that assisted with skill development including substance abuse, child welfare, and group home settings. Three different participants identified how this work experience help prepare them for their school crisis response work.

> *One of my most educational positions was working in a group home for young girls with severe mental health issues. And the typical client was discharged from the hospital and there were a lot of high risk situations that transpired there. I probably learned more than I ever learned in any program in terms of how to assess for suicidality, how to deescalate behavior interventions. They trained you in non-violent behavioral*

intervention. So, you knew holds, you knew how to keep yourself safe. You knew all of that. I never had to use a hold or any physical intervention, however, I was trained in it. And I was prepared on how to deescalate before that were to be an issue. So honestly, I think the hands-on experience by far exceeded anything educational based. I think my job that I had first out of graduate school was my trauma training hands down. And so, we were working with kids that were removed from their parents' custody. And just about every client had a trauma background.

Another participant shared how they noticed a trauma component to their employment in a substance abuse related practice setting.

Well, my early work was in substance abuse and my internship was in substance abuse. And I would say that unbeknownst to me at the time you're dealing with trauma, most of the people you deal with in inpatient substance abuse treatment are dealing with trauma. So, it may not have been labeled that way, but we sort of looked at it more as the chaos that happens through the addiction, but it really is about treating trauma, both in the family and in the individual because we did a pretty extensive family component. And all of those, in retrospect, all of those families were in trauma, like responding to the trauma of living with somebody who needed to be, you know, someone who's an active alcoholic or drug addict who needs to be inpatient. So, by definition, you know, they're all experiencing pretty severe traumatic responses to what an addiction can do to a family. We talked about the chaos, and trying to stabilize again, using the skills of social work, looking at the environment, what was this client going through at the time? And you, you identify all of the events, which in the framework, then it was more like a crisis intervention than a trauma intervention. I, and, and I think now recognizing the we are

more sophisticated about the way that people respond to trauma versus a crisis, because they are different, right. But didn't really label it that way.

Substance abuse settings are often associated with interventions such as harm reduction or motivational interviewing in which the addiction is the primary focus; however, the participant shared that trauma treatment and crisis intervention are often needed secondary to the root cause of and the result of substance use. Another participant who had substance abuse treatment experience concurred and specifically mentioned that they noticed trauma history in particular with first responders and veterans.

I actually worked in inpatient substance abuse for three years. They lived there for about 42 days, so quite a bit of trauma, because I worked with firefighters, police officers, Army veterans, anything maybe you think of in that regard. So yes, a lot of trauma in that. I feel that the hands-on experience definitely helped me with anything.

A common pattern throughout all three of these participants' experiences was that skill development around crisis intervention and trauma can occur in other settings outside of a school setting and these skills can be transferrable. It also introduced that there are different types of trauma outside of the acute trauma of gun violence that social workers need to be familiar with and trained on treating.

The practical experience gained around crisis response and trauma shared by these participants focused on their therapeutic response to clients in which they did not have a shared traumatic experience such as in a community-wide trauma. A participant who had significant experience in disaster response both in the community and the school settings also highlighted the difference between individual versus community traumas and how their years of disaster recovery has contributed to their knowledge base.

> *I think I've learned it by doing. I've been to a number of vigils after a teen suicide. I've been to, like I said, and I've responded to a number of kind of community events, a shooting at a parade, no one died, but again, shooting at a parade, it's very scary. An untimely death of a teacher who had a heart attack walking down the stairs while changing classes and supporting that school then as a result. I think I learned by it over the years. I'll say on a smaller scale, in some ways. Smaller scale as in a death of an individual, as opposed to the mass shooting response.*

Several participants also mentioned that prior to their response to the shooting, they had experiences providing crisis response on a smaller scale to their respective school communities, citing examples such as motor vehicle accidents, death by suicides, and illness-related deaths of students, teachers, and administrators. All the participants acknowledged the importance of instructional education and training especially when it came to trauma intervention; however, the majority felt that crisis response skills were primarily learned and integrated during the practical application. In particular, learning and applying crisis intervention skills in trauma-responsive tertiary settings that are nested within complex systems was beneficial to their preparation.

Building Upon Basic Social Work Skills

Another theme that emerged across participant interviews was the use of foundational and advanced practice work skills. All participants were able to name the foundational social work skills that were used in both micro and macro interventions; however, there were several participants who expressed the opinion that these skills were more instinctual and less taught. Only about half of the participants were able to name advanced practice social work interventions that they used in the crisis and recovery response. Two participants commented that their experience of MSW education was it was very generalist and proposed that social work

education should include the option for specializations. Finally, one participant shared that through their work with the most impacted families, they learned the importance of trauma-sensitive language that they had not previously learned through their training or their years of practice experience.

Foundational Social Work Skills

Participants were asked about specific crisis- and trauma-related interventions they had used in their response and recovery work in the aftermath of the shooting. Specifically, when referring to crisis intervention, all participants mentioned basic social work skills such as starting where the client is at and holding space. A few participants were able to name the additional skills including active listening, reflective statements, and grounding. One person spoke about grounding and creating safety as the most helpful approaches in crisis intervention so the individual could be receptive to intervention.

> *I think we learn how to talk to people and how to understand how people experience different experiences differently. But like grounding has been the most helpful and providing safety, I think has been the most helpful. And then once we have the grounding, the safety, it's a lot of control, so what are we able to control and what can we not control? Those have been like my main foundations of helping deal before and then mindfulness.*

Another participant acknowledged that crisis intervention relies on skills that are general social work skills and reflected that as a more seasoned social worker they were now able to name the skills they utilized. The participant explained:

> *We did intuitively what made sense. We showed up. We were compassionate. We were kind. We were active listeners. We were reflective. We were holding space, but I don't*

> *think I had formal training to necessarily do that. I feel like that those are your general social work skills. I had training as a social worker. I do think that social workers are trained to engage and assess and hold and be reflective. And those are our general skill sets if you will. I definitely have felt like over the years, I probably didn't know that when I first graduated, that those are social work skills. But ultimately those are definitely social work skills. And I now can name them as social work skills.*

Another participant mentioned that crisis intervention relies on basic social work skills, but all support looks unique because:

> *There isn't a formula for crisis intervention, because everybody reacts and responds to things differently. So, there isn't one set way that we can respond to a crisis. There isn't like a, this is the only way to do it and that's it, kind of formula. We could be provided with tools and with support, but that may not actually be of any use.*

About half of the participants were able to identify these skills as components of Psychological First Aid (Brymer et al., 2006; Schreiber et al., 2006)

The participant mentioned above was not officially trained in Psychological First Aid at the time of the school shooting, but later completed an official training. They shared their impressions of Psychological First Aid and its core actions:

> *I think one of the things now, years later, having been exposed to disaster mental health and in particular psychological first aid, I think it basically provides the foundational theory and knowledge of what I was actually doing. It kind of like it legitimizes what I was intuitively doing. There's several core actions in psychological first aid. Contact and engagement being one of them. How do you initiate contact? Non-intrusive, being warm, providing warmth, being genuine, expressing empathy. All things that I think come*

natural to social workers, but I didn't know that's the first step that I have to do. And then I think also around psychological first aid, it talks about safety and comfort. What does safety mean? And it could be, again, this could be people, if you're responding immediately post event to like a fire in a school or something, is everyone accounted for? How do you find everyone? And then also like kind of reconnecting people, reconnecting folks who might have been separated. So, connecting with supports is really, really important. I think about some of those early, early times around kids and parents who were really distressed, like physically and visibly distressed. And the role of kind of stabilizing folks is a core action in psychological first aid and is also a skill of a social worker, hopefully. That you can sit with really distressed people and kind of hold their space with them and reorient them and get them, help them to, I mean, hear their pain and hear their story, but also help them to kind of get to a functioning space again. And I think the last one, I think about the core actions of psychological first aid about like linkage with community services and collaboration. I think that's another kind of fundamental skill of a social worker is collaboration and resource support and referral support and linkage. And those are natural. Those are really solid skills of a good social worker and absolutely something that I had to utilize in my work.

Several participants mentioned core action of Psychological First Aid – providing physical and emotional comfort. They shared stories of ensuring that basic needs were met during crisis response and linked these actions to Maslow's Hierarchy of Needs (Maslow, 1968; Maslow, 1970). One participant shared:

I still remember some of those faces that I sat next to and just brought them water or maybe a sandwich. And just to be present.

Another participant from a different district shared that after the lockdown was released on the day of the shooting, they and other staff went into action facilitating student/parent reunification and providing emotional support. The participant recalled that at the end of the day they ordered pizza for their colleagues before they left for the day. They explained that everyone was tired and still in shock; many had not eaten all day so they ordered a pizza for everyone before they left. They stated that it was important to meet someone's basic needs first.

When asked what guidance they would give to a social worker providing crisis response and recovery after a school shooting, one participant explained:

> *I probably would have said be prepared and be well-trained, but in the moment, I mean, you can never be a hundred percent prepared for that. I think it's more about being a human in those moments and, you know, being aware, paying attention to your instincts as much as possible, you know, trying to play things the safest way possible, but most of people's needs aren't what you'd think they'd be in a crisis like that. It's like, do you need a tissue? Do you need a drink of water? Like it, you wouldn't think like, it's your role as a therapist to do just human type things. Can, can we call your mom? Rather than, okay, let's talk about your feelings. It's not always like that, I wouldn't want anyone to think it's just the basic trainings that you're applying. There's a lot other stuff that goes into it. Being human is the first one.*

This participant emphasized that crisis response needed to start with basic compassion, but referenced that there is more to crisis intervention and recovery response than just instincts.

Instinct Versus Learned Skills

When discussing the skills and approaches they utilized in the immediate aftermath while providing crisis response, all of the participants referenced basic social work skills; however, a

few also mentioned the importance of instinct and personality in being a competent emotional first responder. One participant with extensive disaster response experience explained:

> *I do think that there is, there is something personality driven about being able to kind of stay calm in crisis situations, under pressure that isn't for everyone. There are some folks that, you know, you put them in a situation that's kind of chaotic and they get antsy and agitated so then they probably aren't in their most stable place to be offering support because they're feeling agitated and anxious. I do think some of it is around kind of personality driven and can you handle yourself in crisis situations? Do you have your own capacity to self-regulate because if you can't, then you are not going to be helping anyone else to regulate. I do think that some of it is personality, staying calm under pressure. Some of it is reading the room and some of it is, I think then the more experienced you get and you do these types of crisis responses and you manage things. I've had these multiple events that have required me to not only be a compassionate, active listener, providing some guidance and psycho-education, which I think is a role of a social worker.*

This participant then shared that the initial response to the school shooting – assisting with notification to impacted families and providing support to a community in shock – was an intense situation that required the ability to stay calm and regulate their own responses. They continued that they believe that ability is part personality, part experience, and part trained skills.

Another participant from a different school district characterized her ability to remain calm and self-regulated during crisis situations as instinctual.

> *Beyond my education, I think I have a really good instinct, uh, in this field. And I honestly, I believe that guides me 100% of the time. I know when a crisis is happening*

with a student, how to assess it. If I feel comfortable walking away from it or if I know it needs to escalate. So, the next step, um, you know, I trust my judgment. I feel confident assessing for crisis suicidality, all of that stuff.

Several additional participants used terms such as “instincts” and “being human” to capture the idea that their ability to respond to crises was more than just their social work training.

Advanced Practice Skills

Analysis of the findings reveals that all of the participants, whether they could label the work as Psychological First Aid or describe it in terms of social work skills, provided crisis response to students, staff, families, and the community. Seven of the participants were also active in the trauma-based interventions as the response moved from immediate crisis response toward recovery. Participants varied as far as their estimation of the duration of the immediate crisis response or acute phase of response. Several participants in one district estimated it as eight to 12 weeks while participants from the other district reported that it was several months. Another participant who responded to the same school shooting described the differences in the interventions and approaches during the crisis response versus the recovery.

Well to tease it out, I sort of feel like it (the work) really is more client centered. It's where the client, where the person is at really is sort of whether or not you're doing sort of psychological first aid or whether or not you're doing sort of trauma intervention. And they're different to me. So, crisis, you know, psychological first aid is very gentle and very sort of empathic and very holding. Right. You sort of hold the client when you're doing trauma response. You're, you're more sort of being a little bit more educational and start, trying to help the client piece things together. And when they're in a crisis

> *response, they're not ready to do that. They don't have the sort of cognitive bandwidth to hold on to anything.*

This participant also referred to the reason certain interventions are not utilized sooner in the response and returned to the social work emphasis on "starting where the client is at" even after the immediate crisis phase has finished. Utilization of trauma-responsive treatment interventions required not only the foundational skill of "starting where the client is at" and rapport building through authentic connection, but also the advanced practice skills of determining when a client was stabilized sufficiently to move forward with intervention and which specific intervention.

Of the participants who provided short-term or ongoing counseling in their role, the interventions selected were evidenced-based and trauma-focused interventions. The most popular interventions mentioned included mindfulness, Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Cognitive Behavioral Interventions in Schools (CBITS), Bounce Back, and Eye Movement Desensitization Reprocessing (EMDR). Multiple participants mentioned mindfulness both in the acute and nonacute phases of the response efforts. Psychoeducation about trauma was typically paired with the mindfulness activities to assist students to understand their emotional and physical response to the trauma. One participant explained they used this in conjunction with encouraging self-care.

> *My main thing is mindfulness. I do a lot of square breathing, deep breathing, diaphragmatic breathing with them. Basic self-care is something I go over quite a bit because it feels like children often don't do that, like showering, eating, sleeping. Just to regulate them in that crisis mode. Definitely psycho-educating them about what's going on in their body, the cortisol response, adrenaline, things like that.*

Several participants indicated that mindfulness was an intervention most of them felt comfortable with and that it could be easily paired with other interventions.

> *My backpack of tools that I used when a child was in crisis, having a quiet room to bring them into. We even had a, I forget what we called it, the den, kind of like a little room that we could let kids chill out in for a little bit. But actually naming it CBT or something like that, or it was more so just using mindfulness and breathing were the main things that I would do, just grounding them to reality right then. I would use that part of TF-CBT quite a bit to deescalate them and psychoeducation. But obviously, I would calm them down first and get them grounded to reality and then be able to educate them a little bit.*

Several participants used the words "grounding", "being present", "relaxation", and "mindfulness" interchangeably. Mindfulness appeared to be universally used in both the immediate crisis response and in ongoing trauma counseling. This participant also made mention to mindfulness and psychoeducation being components of TF-CBT. Aspects of mindfulness were used in adjunct to the primary intervention or with actual components of the trauma specific interventions such as TF-CBT and CBITS.

One district had previously trained their social workers on TF-CBT prior to the shooting and continued to train social workers in this intervention upon hire. One participant with significant trauma training discussed initial resistance to using TF-CBT and preferred EMDR as it did not require a detailed trauma narrative. The participant explained that they always provided education on each intervention and then offered the choice to the client. The participant was surprised by the number of students over the years who had selected TF-CBT because they wanted to tell their stories. They provided an example of how they would educate students and caregivers on both TF-CBT and EMDR.

Yes, because I was doing therapy. What I would do is I would explain to the families the difference between the two models. What I would do, which I found very, very fascinating, is I would explain to them the differences between the models. Because EMDR is very little talk about the trauma, I expected everyone to want to do EMDR. But in fact, most of the students wanted to do the TFCBT because they wanted to tell their story. I was just fascinated by that. Of course, I never said to them, "Really? You want to tell your story?" It was something that I would always in my own mind be fascinated with because with EMDR they have to create a picture in their brain that represents the trauma. Then they start the processing. Then you start the processing. There's a change that way, and even though I've done the EMDR with adults and it has fascinated me to see the processing stages, I've had an adult say to me "I'm getting very angry right now and wondering why we're doing this," that type of thing. But it was part of the processing the trauma. The students didn't want to do it as much. I think I might have had one student that wanted to do it, but the rest of the students wanted to tell their story. I was just amazed.

The participant explained that they always had concerns about TF-CBT because they did not want it to be potentially retraumatizing to the student; however, after practicing it more they realized that the trauma narrative is completed in later stages of the therapy.

TFCBT, I was resistant, I will say, for the same reason as a lot of therapists because the student has to tell incredible detail of their abuse, what were they smelling, what did the room look like, what was said, can they see it. It's very, very intense detail. Initially, I had a resistance to it myself, for myself basically. Then once I saw how successful it was, then I lost my concern about it. I was then able to put my own personal part aside. That's one

of the problems with TFCBT and therapists utilizing it for the first time, is that we're do no harm and so people think if I have them talk about it I'm going to harm them. And actually, you don't. Actually, you don't have them talking about it until they're really prepared in a lot of other ways. You don't start with the trauma narrative so that by the time you do start with the trauma narrative, and the way the trauma narrative is processed from the get-go, it's not harmful to them.

Another participant from a different school district who was also well-versed in trauma-focused, evidence-based interventions discussed that these interventions have positive outcomes and research to support their use; however, strict adherence to the treatment protocols at the expense of relational work impaired engagement with students.

I think evidence-based practices really limits your ability in the relational development when working with students. Having the handbook or the materials, it almost acts as a barrier to developing a relationship. And maybe specifically for teenagers and engaging. Even though I relied on it, I didn't necessarily ... to be honest, I didn't really necessarily follow the protocol completely because it was hard to engage students in another activity where they felt like they were being lectured to. Certain clients, it wasn't appropriate for. But it did provide a framework after the relational development, after building that relation with the client, to rely back on certain interventions or handouts that it did ... we incorporated it into it. But for most students that we're trying to engage in the evidence-based practice in the client therapy room, working on a worksheet felt more like school and there was a lot of resistance. Everything is relational, right? Every single thing that we do with them is relational, building and start ... Honestly, it goes back to first year

> *graduate program, starting where the client's at. Right? Meeting them where they're at in that room.*

This participant reinforced the social work concept of "starting where the client is at" which every participant emphasized needs to be a component of any intervention whether acute crisis or in any of the trauma-based therapeutic interventions. This participant emphasized that the relational aspect of the work should not be undervalued by strict adherence to a treatment protocol. The therapeutic relationship is a core component of any trauma treatment in order to create the safety and trust in which to implement the intervention.

Using Trauma Sensitive Language

A component of any intervention is the language used and social workers have been trained to be thoughtful communicators. During exploration of the response to the most impacted families, one participant shared insight they gained around trauma-sensitive language. In particular, the participant noted social work professionals' inclination to use therapeutic language to soften the communication. The participant shared what they learned either through direct feedback from the families or through observation of family reaction to others using this language.

> *I have learned that I do not use any language that is clinical or therapeutic in our profession because a lot of it is quite activating for families. It's only in follow-up conversations I've been told never to use those words because either I've used them or mostly it's I'm in a meeting and somebody else has used them. I think people are often uncomfortable around the words, murder or massacre or even death. I used the word, those who were lost. I won't use that word again. The answer was my child was not lost. He was murdered. Any time that I have had a new person come into working with*

> *families, I always educate on the language that I use. It has made a tremendous difference.*

The participant shared a detailed list of words and phrases that professionals tend to use in communication, and which could be potentially activating to families.

- *We often say how are we going to execute that plan or that something is a trigger.*
- *I always use family, not parents because we had adults who were murdered.*
- *Event and Anniversary are happy occasions.*
- *Incident is not severe enough.*

The participant shared their best practices around communication with the families and suggested some potential reasons as to the reaction to language that is softened.

> *Tragedy, killed, murder. I name it. I don't think people like hearing the death of their loved one minimized, because it's easier to say lost than murder. Like, you know, like if you say, well, the incident, it wasn't an incident, an incident is something that happens and typically you can resolve things like that. Incident wasn't strong enough. They don't want to hear loss. They want to hear murder because that's the actuality of what happened. I was very uncomfortable, honestly, starting, I would always try to be sensitive, but sometimes our sensitivity is minimizing their experience. And we need to be careful that we are not minimizing the death of a person that they love and hold dear. so, we just need to be careful how we use our words.*

The use of language that is both trauma sensitive and does not minimize the experience of the victim for the sake of sensitivity is an important finding. Foundational social work practice includes the importance of effective and thoughtful communication; however, buffering can occur under the assumption of protecting the victim or for the comfort of the social worker.

Generalist Versus Specializations

Every participant was asked what they would recommend be included in a MSW curriculum to assist school social workers to be better prepared to respond to crisis and trauma in the school setting. Two participants reflected on the generalist nature of social work education and the fact that most MSW programs are focused on generalist or foundational skills. One of the participants explained the benefits of generalist training and the drawbacks when it comes to school social work practice.

> *I felt that social work was different in that when you get trained to be a social worker, your career options are so vast. You could get into the political arena, you could get into the legal arena, you could get into the community health arena. You could get into hospitals, you could get into a million different places that a social worker can work a school, a private practice. You could do a million different things, things that are clinical things that are research-based things that are teaching. I mean, just so many different things, case management options are vast. I felt like, because those options are so vast, it must be because the training is different, right? Like we are trained more so on policy. We are trained more so on all the history of social work, more so than the practical skills to apply it. Yes. We take four courses on the practical skills. Honestly, I feel like we should be given an option in school to take more specialized courses.*

The other participant echoed the sentiments that the MSW degree is very broad and that it would have been helpful to have the option for more specialization.

> *I didn't realize while I was in my master's, you can get this very broad degree. But it would be great to have something to kind of really focus on.*

For these participants there was a recognition that their MSW curriculum did not fully prepare them for their work in schools and the desire that social work education allow for the choice between a generalist and more specialized course of study.

The current K–12 school landscape in the United States is fraught with acute and collective trauma on both the individual and collective levels. Foundational social work skills are the building blocks that all participants relied on to develop relationships with students, teachers, and families in order to provide crisis intervention. Although not all participants could identify the specific names of these interventions or recognize that what they labeled as instinct was actually skills learned through social work education, they were able to effectively provide support and facilitate linkage with ongoing services. All of the participants emphasized the relational aspect of social work practice as critical to both crisis intervention and the advanced practice of trauma treatment. The importance of relationship and connection is a common thread throughout all of the findings. This identified theme assists with answering the questions in this study pertaining to education and training. Specifically, did they feel prepared by their MSW education and training to provide crisis intervention and trauma recovery support and what did they learn from this experience that could have implications for advancing social work education.

A significant finding is that all the participants reported the importance of practical application of skills either through a MSW field practicum or post-MSW employment. This finding reinforces that field education should remain as the signature pedagogy of social work education (CSWE, 2018). Another critical finding is that the foundational skills of social work practice learned in MSW education were sufficient to effectively prepare participants for crisis

response. Implications for consideration in MSW social work education would be the option of allowing students to select more specializations within their programs. Participants reported that the advanced practice skills utilized for the trauma treatment portion of the response were gained through post-MSW certification or training and not through their MSW education. Finally, although self-care was incorporated within the latest revision of the NASW Code of Ethics (2021), social work educators have the opportunity to reimagine how to operationalize it better within their curriculums in particular to prepare social workers for the experience of shared trauma. Finally, it should be noted that the majority of participants commented that no program or training could fully prepare them for the overwhelming aspect of responding to community trauma caused by mass targeted gun violence. The experience did reinforce for them that during times of such tragedy it is human instinct to seek comfort and safety through connection with others.

CHAPTER SEVEN

Discussion and Implications for Future Research

This study explores the experiences of school social workers employed at a school that experienced targeted school gun violence or social workers hired/contracted in the immediate aftermath by a K–12 school that experienced targeted violence. Participants shared their experiences providing crisis response and recovery services to the students, staff, parents, and school community. Two interviews were conducted per participant to allow for prolonged engagement and deeper sharing of their experiences. Each participant provided their reflections of this highly stressful time in their professional careers. This study had multiple goals including learning: (1) did they feel prepared by their MSW education to provide crisis intervention and recovery support? (2) what were the professional and personal impacts of providing this support and (3) what did they learn about their practice providing these services?

Three major themes have emerged in the findings: the power of connection, the impact of trauma, and the gaining of social work skills/knowledge. Both the Ecological Systems Theory and Relational Cultural Theory (RCT) were the proposed theoretical frameworks through which to view these findings. Participants focused primarily on the relational quality of their response and recovery work both with individuals and systems rather than on the mere interactional aspect of their responsibilities within the school system. The participants recognized the importance of the relationships embedded within the various levels of the system; however, the systems aspect was more implicit within their responses. In a broad sense, participants acknowledged their additional work responsibilities within the system and how the system influences the logistics of their work; however, relationship and connection were the explicit themes throughout all their

responses. Systems details were referenced primarily to describe the situations in which relationship building was either enhanced or impaired on the various levels.

Reenvisioning Emotional Support for the Emotional First Responders

All of the participants acknowledged the intensity of the experience and how the crisis response work in particular impacted them professionally and personally. The most significant finding is the universality of secondary traumatic stress (STS) symptoms that occurred among the participants. All participants noted some negative impact ranging from an intense and obsessive interest in media, to sleep and mood disturbances. In particular, those who were employed at the time of the shooting and experienced the shared trauma reported experiences of increased anxiety, mood lability, and boundary issues with students and families. All participants, both those with shared experience of the trauma and those who were hired in the immediate aftermath, reported sleep disturbance, exhaustion, times of countertransference or reactivity, and the heaviness/burden of holding space for others. All participants acknowledged that they recognized the signs of STS, but prioritized their responsibilities to their students and the community before their own healing or self-care. This finding confirms previous research (Fein et al., 2008; Day et al., 2017; Austin, 2003) which indicated that counselors responding to mass targeted gun violence often knowingly allowed their needs to be superseded by the needs of the crisis response efforts.

Participants of this study and the aforementioned studies were emotional first responders to unimaginable tragedies. Author Rachel Naomi Remen (1996) has likened the cost of caring as "the expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet" (p. 52). One of the participants, who had significant experience as a disaster first responder prior to the school

response, shared a similar sentiment – that the traumatic impact of being an emotional first responder is inevitable. The questions then arise: how do emotional first responders such as school social workers responding to targeted school violence manage the impact of STS? What type of programs can be developed and implemented to care for the caregivers? These programs must recognize that social workers employed at school sites at the time of the violence are also victims, potentially experiencing primary and secondary traumatic stress simultaneously.

Participants in this study who experienced shared trauma identified self-awareness and boundary management as protective mechanisms to self-regulate their empathy and emotional response (Newell et al., 2016). The three school districts represented in this study offered their social workers counseling through either Employee Assistance Programs or similar resources in addition to self-care activities such as mindfulness; only one third of the participants accessed these resources. Some said they were too busy during the day and didn't have time after work. Others said they consciously didn't access the supports or process their experience in order to compartmentalize their feelings around the shared trauma as self-protection. One participant shared that they didn't want to speak to an unfamiliar counselor who was just on site for a few days; rather, they would have preferred support from colleagues who they perceived understood their experiences and with whom they already had a relationship.

Processing and Debriefing as a Supportive Resource

All of the participants, both those who experienced shared trauma and those hired in the aftermath, shared the importance of connection and relationships to managing the impact of crisis response, especially during the immediate and intermediate phases of the crisis. The most desired connection was primarily with others who they perceived could understand their experiences and could emotionally handle the information. Participants used terms such as

"processing", "debriefing", or "decompressing" to describe the ability to share their feelings with their colleagues around the impact of hearing the victims' stories and the stress of providing support to a traumatized environment. Only two participants were reportedly offered the formal opportunity to debrief or process their feelings with colleagues on a regular basis. These participants were offered group supervision which struck a balance between case consultation and processing. Four additional participants were offered a one-time only processing/debrief meeting with the other mental health disciplines within their district in the immediate aftermath of the shooting. These participants expressed their appreciation for the meeting and the desire that this type of support had continued throughout the response.

Those participants who were only offered this single meeting, as well as the additional participants who were not offered any formal opportunity to process with colleagues at all, organically connected with their colleagues for support in nonformal ways. Three of the participants stated that they found the time to process their experiences on a regular basis with an individual colleague within their team or department. Two additional participants reported that their department or school support staff created their own "check-in/process" group every day as a way to ventilate their feelings and engage in self-care. These informal ways of connection that developed organically highlight the importance of relationships especially when experiencing trauma (Abrams & Shapiro, 2014). Relational Cultural Theory, a theoretical pillar for this study, suggests that relational resilience occurs through growth-fostering relationships with mutual empathy and authenticity (Jordan, 1992, 2001, 2018; Banks, 2015). Through an RCT lens, it is not surprising that these participants developed their own way of authentically connecting with their peers.

The idea of "processing" or "debriefing" has been a component of first responder supports since the development of Critical Incident Stress Debriefing (CISD), also known as the Mitchell Model (Mitchell,1983). CISD is a seven-phase intervention model delivered through individual or group modalities to first responders to facilitate a discussion on their feelings around the traumatic event within one to 10 days after its occurrence (Mitchell, 1983; Feuer, 2021). A component of CISD that has drawn criticism is psychological debriefing, which is usually a one-time session to process details and feelings of the event. Criticism of psychological debriefing has included the lack of empirical data that supports its efficacy and the possibility of it being further traumatizing by impairment of the natural healing process (van Emmerik et al., 2002). Literature actually recommended that psychological debriefing not be a mandatory component of any first responder support (Rose, 2003; Litz et al., 2002; Roberts et al., 2009). In 2012, the World Health Organization (WHO) strongly recommended that psychological debriefing not be utilized with individuals recently exposed to a traumatic event.

Feuer (2021) suggested an alternative approach, Psychological First Aid – Listen Protect and Connect (PFA-LPC) which was developed by Merritt Schrieber, Robin Gurwitch, and Marleen Wong in 2006. PFA-LPC is a common, immediate, crisis-stage intervention used in schools by both helping professionals and non-mental health staff to create safety and linkage to supports. Feuer (2021) supports the use of PFA as an intervention for first responders because it does not include a discussion of the trauma event, but rather focuses on immediate needs and present concerns. Only one third of the participants in this study availed themselves of counseling supports and services in the immediate and intermediate phases of crisis support. When asked about a potential reason for not accessing services, one participant explained that as a social worker they didn't feel the need to engage in an intervention that they are qualified to

administer. This researcher questions whether emotional first responders such as school social workers would voluntarily participate in psychological first aid as an intervention for themselves after a crisis. The findings of this study, in conjunction with supporting literature, indicate that social workers are at high risk for STS due to the nature of work. Given this data, this researcher suggests that PFA-LPC be expanded to focus on the relational, supervisory, and ongoing needs specific for emotional first responders.

Format of Effective Supervision

Eleven of the 12 participants received some type of professional group supervision/meetings during the immediate and intermediate phases of crisis response; however, the majority did not feel that those meetings provided the opportunity to demonstrate vulnerability and process their feelings around the weight of holding space. For the majority of participants, group supervision focused on case consultation and logistical response rather than processing. Participants acknowledged that they did find value in case consultation and logistical planning. For participants in one specific district, case consultation assisted with managing their stress around the intense scrutiny from their community. Several participants reported that they also found individual supervision time helpful. These participants mentioned their supervisors allocated individual time to review not only clinical work, but also the impact of the work on their well-being. One participant mentioned that their supervisor provided them a safe space to be vulnerable and provided ongoing reminders about boundary management, social supports, and self-care activities.

Supervisors responding to crises are often under the same pressure as direct practice social workers in addition to the stress of their administrative responsibilities. Supervisors may benefit from their own support as well as specific guidance or a protocol on how to structure

supervision to be the most helpful to not only their social workers, but their own well-being. Case consultation, logistical planning, and processing are all critical components of effective supervision during crisis response. Future studies are needed on effective supervision during crisis response as well as how specifically supervisors manage their potential STS given their direct practice, supervisory, and administrative responsibilities.

Self-Care in Social Work

Literature on STS has encouraged counselors to engage in "self-care" most often including exercise, good sleep hygiene, supervision, and connection through relationships, either personal or collegial (Maslach, 2003; Lakey & Cohen, 2000; O'Halloran & O'Hallaran, 2001; Zimmering et al., 2003; Wagaman et al., 2015). The idea of self-care was referenced by participants when discussing managing the emotional impact and the symptoms of STS. Specifically, not having the time to engage in self-care and prioritizing the well-being of others first. Self-care was recently added to the National Association of Social Workers (NASW) Code of Ethics in 2021 as a preventive reminder to encourage longevity and professional satisfaction. The new language in the Code of Ethics includes the following:

> Professional self-care is paramount for competent and ethical social work practice. Professional demands, challenging workplace climates, and exposure to trauma warrant that social workers maintain personal and professional health, safety, and integrity. Social work organizations, agencies, and educational institutions are encouraged to promote organizational policies, practices, and materials to support social workers' self-care. (NASW, 2021)

In addition to this preventative reminder being added to the code of ethics, many MSW programs infuse self-care education into their curriculums. Despite these efforts, national studies

on self-care in the social work profession indicated that social workers endorse and engage in moderate self-care or on a limited basis (Miller et al., 2019; Bloomquist et al., 2015; Miller et al., 2018). Part of the disconnect may be the lack of a consistent definition of what self-care is exactly, since it is both a construct and a practice (Miller et al., 2019). The following definitions of self-care have been proposed:

- "Self-care as a choice and commitment to become actively involved in maintaining one's effectiveness as a social worker" (NASW, 2018, p. 246).
- Personal "self-care as a process of purposeful engagement in practices that promote holistic health and well-being of self" and professional self-care as "the process of purposeful engagement in practices that promote effective and appropriate use of self in the professional role within the context of sustaining holistic health and well-being" (Lee & Miller, 2013, p. 98)
- Self-care is practice-oriented activities within multiple domains (physical, psychological, spiritual) that promote overall well-being (Newall, 2017).

All of the participants in this study who graduated from MSW programs within the last five years mentioned concern about how self-care is taught and encouraged in MSW programs. They reported that their respective programs taught about the importance of self-care as well as provided examples of self-care within the curriculum; however, when they reportedly requested time to engage in self-care, it was denied reportedly due to responsibility to the field agency or to the demands of the course requirements. These participants expressed concern that the social work profession is talking about the importance of self-care, but not committed to allocating the time for students to practice.

A lack of engagement in self-care, especially in the immediate and intermediate phases of the crisis response, was a common theme among the majority of the participants. All of the participants' districts provided the option of school-offered self-care supports such as mindfulness, yoga, and other group-based wellness activities. One participant suggested, it would have been helpful to have been given the time to engage in these activities during the work day. Another participant indicated that they felt the primary obstacle was not time, but social workers' tendency to place the well-being of others over their own. This troublesome pattern does not seem exclusive to social workers as literature noted other helping professions experienced concerns around lack of self-care and the rates of STS (Figley, 1995; Bride, 2007; Wagaman et al., 2015; Radey & Figley, 2007; Stamm, 1998; Newall, 2016). Future research around self-care and social work is needed to determine if time, the culture of social work, or other pressing and unknown factors are the primary reasons that self-care is not fully embraced. Future studies should also examine the generational influence on the perception of self-care and work/life balance, specifically how it may vary from Generation X to Generation Z. Inclusion of self-care language alone within the NASW Code of Ethics is not a sufficient response to the problem of STS and burnout. Given the emotional intensity of crisis response work in general across all practice settings, self-care should be not be only incorporated within trauma response plans, but reimagined beyond merely engaging in mindfulness or taking days off from work.

Preparation for School Based Social Workers

This study also explored the extent to which social workers felt prepared by their MSW education and training to provide response and recovery services after targeted gun violence in schools. All of the participants shared the disbelief they felt after gun violence occurred within their communities and the idea that no one is ever fully prepared to respond to such

unimaginable violence. Participants explained that crisis response knowledge and skills are needed and used on a daily basis in schools and not specifically related to school gun violence. Examples shared of other crises that required a community response included death by suicide, car accidents, sudden death by illness, overdose deaths, and other forms of violence on school campus. In 2012, the National Association of Social Workers (NASW) developed the NASW Standards for School Social Work which outlined the 11 standards of social work practice including: ethics, qualifications, assessment, intervention, decision making, record keeping, work management, professional development, cultural competence, leadership, and advocacy. These guidelines outline best practice in school social work, but do not specifically mention trauma interventions. This is particularly troubling given the prevalence of acute and accumulative trauma in schools. The Council on Social Work Education (CSWE) outlines learning competencies essential for social workers in the Educational Policy and Accreditation Standards (EPAS) including the practice-oriented competencies of engage, assess, intervene, and evaluate practice with clients (2015). Both the NASW School Social Work Standards and the CSWE EPAS reference the use of evidence-based practice; however, neither standard emphasizes the importance of understanding the theoretical reason supporting the use of these interventions and the importance of learning these interventions within different contexts.

Basic Social Work Skills

All of the participants indicated that they felt prepared to utilize basic social work skills in the immediate phase of the response. Terms such as holding space, linkage to resources, active listening, validation, meeting concrete needs, and empathy were used to describe the social work skills used in their response efforts. About half of the participants were able to name these skills as associated with Psychological First Aid and discussed the theoretical

underpinnings of PFA after targeted gun violence. Several participants described these skills as either "instinctual" or "personality based". This researcher would like to propose that personality, the ability to have flexibility and empathy, are important in social work; however, the skills detailed by participants are learned skills within the MSW training and not based on instinct. Attributing these skills to instinct is tantamount to the idea that anyone can serve effectively in the role of emotional first responder. Instinct is likely being confused for the comfort and clinical knowledge that accompanies practice experience. Participants' confidence in their knowledge and practice of basic social work skills essential to crisis response is consistent with the Werner (2014) study which revealed that school social workers felt moderately prepared for response to crisis in schools. The findings of this present study provide further evidence that MSW programs are effectively training social workers in general skills; however, MSW programs may have the opportunity to better label these skills and the theoretical underpinnings for their use in crisis response. A required course in trauma response, such as Psychological First Aid, might be beneficial for all social work students in order to learn how to use basic social work skills within the context of triaging a crisis.

Advanced Social Work Skills

The findings of this study reveal the importance of building and maintaining knowledge of trauma and interventions in the intermediate and long-term phases of the crisis response and recovery. Those participants who were trained in trauma treatment gained this knowledge through voluntary trainings and post-MSW certifications. One of the districts had a training program which included TF-CBT that predated the shooting in their community. Other participants engaged in post-MSW trainings and certifications of their own accord and from their own personal interest. Through their experiences, participants reported that recovery is a long

process and that the impact of the trauma is often expansive, overwhelming, and not time limited. Two participants shared their belief that social work education is too generalist in nature compared to other mental health professions within the school setting and would have preferred their programs offer the option for more specialization. The benefit of a generalist program is the transferable nature of skills to different practice settings outside of the school setting, but does this lack of specialization fail to adequately equip school social workers with the ability to intervene with acute and cumulative trauma so prevalent in US schools? Foundational social work theories and social work history is an important tradition in social work education; however, is it time for social work education to embrace more current theoretical frameworks such as the Neurosequential Model of Therapeutics (Perry & Hambrick, 2008) to better prepare school social workers to address crisis and trauma in schools?

Is trauma-related training even the responsibility of MSW programs? Should state certification programs or school districts assume responsibility for advanced and specialized training for social workers? Currently there are no required national standards for school social workers and the certification requirements across states vary greatly. Many states only require a Bachelor's of Social Work (BSW) degree for this role. The School Social Work Association of America (SSWAA), the largest school social work professional organization in the US, recently launched a national certification program; however, it is voluntary. Also, there is currently limited information on the specifics of the SSWAA curriculum unless enrolled so this researcher could not confirm that this program even contains training on trauma responsive interventions.

Knowledge Gained About Trauma

One of the final themes that emerges from the findings is the importance of specific trauma knowledge both in the response and recovery after targeted gun violence in schools.

Participants shared that the immediate response is often intense and overwhelming due to the collective shock, trauma, and grief. Participants expressed the idea that their communities would never be the same after such violence. Understanding their social work role, or roles, within each phase of the response effort, and being knowledgeable of the most effective interventions during those respective times, were critical. Participants also expressed the importance of understanding the developmental and neurobiological impacts of trauma on the brain given the school practice setting is focused on learning and academic achievement.

Learning About Trauma: Expanding the School Social Worker Client Purview

Strozier (2011) coined the zones analogy in his post-9/11 study to characterize the range of responses after collective trauma based on proximity to the disaster. The findings of the present study confirm the significance of exposure, proximity, and relationship in the severity of responses from students, staff, and the community. All of the participants provided response and recovery support to students and faculty ranging from being in direct danger (zone 1) to witnessing the shooting (Zone 2) to those who experienced indirect but significant impact from the shooting (Zone 3). Participants offered multiple examples of student and staff experiences as they pertained to exposure and proximity in relation to the intensity of their responses. Although the zones were applicable to the impact of trauma within these findings, participants also emphasized protective factors such as positive relationships (growth-fostering) and access to early intervention/treatment which contributed to relational resilience. Structuring and providing resources with the guidance of the zones concept can be useful when school departments assign and allocate treatment resources to the school community. The zones concept is also helpful to capture the different responses from emotional first responders such as school social workers. Eight of the 12 participants of this study were employed at their districts at the time of the

shooting and experienced shared trauma. These participants in particular expressed more severity in STS symptoms than the participants hired in the aftermath of the shootings; however, all of the participants reported experiencing some symptoms of STS as a result of providing crisis response and recovery services.

Supporting Staff and Faculty

Participants across the three school districts expressed the importance of supporting impacted staff and faculty. Staff and faculty needed emotional support and guidance on how to resume instruction and learning within a traumatized community. Faculty struggled with reconciling their own trauma and the expectation from school administration to resume normative learning. In two of the districts, faculty were trained in Psychological First Aid and returned to the classroom reportedly sooner than they would have preferred. One participant surmised that their district likely incorrectly assumed that the faculty could manage trauma better than students because they were adults versus children or teens. Faculty sought guidance from social workers about possible trauma responses, what to say to students, and how to transition back to academic teaching. Social workers in one district developed "talking points" and a list of resources for teachers to support their return to the classroom. Another area of concerns for some participants was the amount of support for nonteaching staff. One participant shared that the bus drivers, maintenance, and cafeteria workers were not included in the response efforts. The participants emphasized that these staff members were also experiencing trauma and grief which could have benefited from intervention. It would be important for social workers and school districts to recognize the need for more expansive and inclusive supports services after such significant community tragedies.

Working With Impacted Families

All of the participants shared that to varying degrees they provided support to families in the community during the response and recovery phases. The majority of participants reported that parents were in shock and expressed fear that their children were no longer safe in school. Psychoeducation around trauma and linkage to community supports were provided to concerned parents. Four of the 12 participants worked directly with the most impacted families. These participants shared the following lessons learned:

- The importance of a specific attention and unique approaches between the most impacted families: those who had loved ones murdered versus those who had loved ones injured.
- The use of trauma-sensitive language which reflects the reality of the situation for the most impacted families. For example, students were not "lost" rather the students were "killed" or "murdered".
- Two of the districts utilized one assigned social worker to provide individualized support to all the families which included all communication, problem solving, and accessing of resources. Several participants recommended one family liaison to coordinate the support and services.

Trauma Treatment Is Ongoing

One of the participants stated trauma recovery is "a marathon", referring to the intensity and the duration of the response and recovery process. All of the participants acknowledged that their communities changed irrevocably, explaining that the trauma is often reactivated by time remembrances, sensory reminders, developmental milestones, the pandemic, and additional school shootings reported from around the country. Participants discussed that they needed to provide additional support during these times to "reset" the students, faculty, and parents. The

idea that the recovery phase never ends with the continual reactivation of symptoms was suggested by several participants.

Social Media and News Coverage

Social media was a polarizing topic among the participants as some recognized the benefit of connecting individuals to virtual resources as well as its function as a form of mass communication about funerals, memorials, and advocacy events. The majority of participants recommended limiting access to social media both for students and themselves as they viewed social media as divisive and potentially retraumatizing. Examples were provided of rumors and false information perpetuated through social media which caused division among the school community. A primary concern with social media was the viewing of the actual shooting or the aftermath of the shooting which was captured on cell phone footage. Viewing of these images, often repeatedly, exacerbated the symptoms of those who experienced or witnessed the shooting in real time and created a collective traumatic experience for others who were indirectly impacted. One participant equated it to watching the World Trade Center buildings collapse on 9/11 over and over again on news footage.

Four participants across two districts interacted and engaged with the news media in an official capacity on behalf of the district. Three of the four expressed concern about the accuracy and intent of the news media in the immediate aftermath. One participant shared that on numerous occasions their words were taken out of context to emphasize the negative aspect of the district's or law enforcement's response. Additional participants who did not have direct interaction with the news media also expressed concern with how their towns were overwhelmed with news people, trucks, helicopters, and satellites. Community members reportedly became frustrated and distrustful of the news outlets and the intent of their coverage.

General Recommendations to School Districts

Over and over again, participants stated that their communities are forever changed; therefore, it is critical for school districts to understand that response and recovery is not short-term in nature. School districts should ensure that they have social workers on the school crisis team since their work with students, staff, and parents are crucial in the recovery. Social work knowledge is important not only for direct practice, but also from systems and logistical perspectives. Social workers are trained to effectively navigate and communicate within and between large and small systems. School districts would be wise to include social workers in all levels of planning and response before and after crisis events. Participants discussed that their districts experienced several crises before and in the aftermath of the school shooting, including death by suicides, illness, and motor vehicle accidents. School social workers are required to respond to crises on a smaller scale on a regular basis. These experiences may even be more likely in districts impacted by targeted gun violence. Critically, these additional losses may reignite the school community's traumatic responses, requiring ongoing maintenance and support work by school social workers and reinforcing the need for trauma-specific training and a long-haul approach to community care.

It would also be important for school districts to understand that the zones of proximity, which describe the direct and indirect impact of trauma based on proximity, exposure, and relationships, are not student specific. Teachers and staff are equally impacted. Therefore, sufficient supports need to be provided particularly in the immediate aftermath of the crisis. Thought and planning should be given to not only mental health supports, but guidance on how teachers can speak with students and restart classroom learning. School districts should also recognize that social workers and other school-based mental health counselors maybe

experiencing shared trauma. Participants' experiences spoke to the importance of school district administration planning from a systems level, not only for the response plan for students and the school community, but also for the school-based emotional first responders providing those services. Based from this study's findings, the following recommendations are offered for consideration for school districts in their crisis response planning specifically during the immediate and intermediate phases of response specifically to support their school-based mental health professionals:

- Provide school-based social workers and other responding mental health professionals the opportunity to participate in individual or group processing.
- Ensure that supervisors balance their supervision time between practice-oriented case consultation and self-care-oriented processing.
- Provide supervisors guidance around support for themselves and their social workers.
- Provide these opportunities for support and processing during the work day and not in addition to the work hours.

Careful consideration should also be given to the support provided to the most impacted families. Particularly important is the recognition of the different needs of those families whose children were killed versus those whose children were injured. Those participants who worked directly with the families stressed the importance of not meeting or communicating with these families in one large group due to the different needs. They encouraged that one social worker be assigned to be the liaison to the families in order to build relationships and provide individualized needs. Work with the most impacted families is specialized in that it requires personalized case management as well as counseling skills. Crisis response and recovery is

complex, layered, and long term in nature. Participants expressed that no community can be prepared to respond to the unthinkable horror of mass targeted gun violence, but school districts can develop a knowledgeable school crisis team and plan with the assistance of their school social workers.

Revisiting the Theoretical Frameworks

Relational Cultural Theory

Relational Cultural Theory (RCT) was one of the frameworks selected to assist with design of the study and interpretation of the findings. Constructs from RCT have emerged as common themes throughout the data. Social work is a relational profession and relationships are often viewed as a primary vehicle for change and healing of trauma (Applegate & Shapiro, 2005; Abrams & Shapiro, 2014; Herman, 1992). All of the participants in this study shared that the trauma and fear of the shooting caused rupture and disconnection among the school and larger geographic community. Jordan (1992, 2001, 2018) and Banks (2015) have noted that acute disconnection and repair is normative and that distress and impairment are caused by chronic disconnection. The shock, fear, and grief in the aftermath of a traumatic event can lead to chronic disconnection, both in the loss of safety and the desire to isolate for refuge (Jordan, 2018).

RCT proposes that mutual empathy and authenticity through growth-fostering relationships can allow for relational resilience and empowerment (Jordan, 1992, 2001, 2018; Banks, 2015). Succinctly, RCT constructs suggest authentic, mutual, and power-with relationships lay the groundwork for healing to occur. Participants described the ways in which the students, staff, parents, and even communities that experienced similar trauma connected with each other. Mutual empathy and authenticity in relationships between social

workers/students, social workers/colleagues, and students/students was crucial in establishing and repairing connection and reestablishing some semblance of safety given the level of fear and shock from the shootings. Students sought to connect not only with social workers, but with each other in informal ways through group counseling and advocacy work with other impacted schools across the country. Social workers also expressed the comfort they sought through connection with colleagues who they perceived understood their experience. Relational resilience and empowerment were fostered through the development and maintenance of these growth-fostering relationships across the school communities.

The interventions used by social workers such as Psychological First Aid (PFA), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), and Cognitive Behavioral Interventions for Trauma in Schools (CBITS) all contain components of reconnection to enhance stabilization and healing. RCT literature extols the importance of connection as a human instinct. This runs counter to mainstream societal values of industrialized, western nations that value independence and self-reliance (Jordan, 1992, 2001, 2018; Banks, 2015). The examination of the traumatic impact of targeted shooting in schools reinforces that trauma can cause disconnection across personal and systems levels and incite profound fear and grief. And engaging in meaningful relationships can promote reconnection and healing from these ruptures. The findings of this study support the application of RCT concepts in practice and emphasize the importance of relationships in healing after profound crisis. Understanding the rupture in trust with physical and emotional spaces caused by violence creates, and recognizing the importance of reconnection in healing, are important information for school districts and outside providers to consider as they are working with traumatized school communities.

Ecological Systems Theory

Participants explicitly focused on the relational component of their work in the response and recovery work; however, the need to understand and work within the school and community systems was implicit in their responses. Participants' knowledge of systems functioning assisted in their ability to effectively navigate the various levels of the school system to be effective first responders. Both in the micro and mesosystem levels during the immediate and intermediate phases of the crisis, participants provided intervention to students, faculty, staff, parents, and the larger community through Psychological First Aid, psychoeducation, resource linkage, and community forums. Participants focused on creating safety, stabilization, and reconnection to the school and others within their traumatized communities. This work also required participants to be able to assess and intervene with and for multiple constituent groups, some with unique interests. For example, parents whose children were injured had different needs and interests from those parents whose children were killed in the shooting. Participants had the skill and knowledge to serve and advocate for the various constituents within the mesosystems level.

Participants recognized the influence of exosystem structures in school policies and procedures, in interactions with families and the media, and in the lack of privacy in the response setting or the stress of community judgement through social media. They recognized macrosystem structures in the national news cycle coverage, the lack of gun legislation or advocacy, and the national culture that anticipates school shootings rather than prevents them. Participants demonstrated the ability to navigate the confines or challenges of these influences. Given social work knowledge and experience working within systems, it is recommended that school districts include social workers in macro-level planning and crisis response. Werner (2014) in a study of school social workers responding to school crises revealed social workers had more confidence in their own ability and their school's ability to respond if they had the

opportunity to be an active participant in the response preparation and planning. Active participation by social workers in macrosystem planning revealed not only an increased confidence in the ability to respond, but in the perceived efficacy of the response.

Strengths and Limitations of Study

This study focused on three schools that experienced mass targeted gun violence. Due to the sensitive nature of this topic, the still-traumatized communities, and the legal implications, protecting confidentiality was imperative. The publicity associated with targeted school shootings within the last 20 years prevented the inclusion of specific data that had the potential of revealing school district identities. Future analysis of school community demographics, such as a district's racial or socioeconomic status, could provide further information on the experiences of gun violence, identifiable and actionable risk factors, and effective assessment and treatment interventions for impacted communities.

Due to the sensitive nature of the research topic, recruitment was also a challenge within this study. Recruitment efforts through social media, professional organizations, and email outreach were all unsuccessful. Given the trauma, legal implications, and media scrutiny in the aftermath of these shootings, it was understandable that participants were hesitant to respond to unsolicited outreach. To support effective recruitment, this researcher was personally introduced to either the school districts or social workers within the school districts through trusted colleagues. Following these introductions, purposive and snowball sampling enabled recruitment of a total of 12 participants. There were multiple participants from each district to prevent one single point of view of the response and recovery; however, limitations include a small sample size given the number of social workers across the three districts. Another limitation is that these interviews were conducted retrospectively, several years after the shooting

and with great variation in time since the shooting, so recall of their experiences can be impacted by time and ongoing recovery. The passage of time is also a strength of this study as interviewing participants too soon after the shooting may have been retraumatizing.

Conclusion

This study highlights the extensive traumatic impact of targeted gun violence in schools on students, staff, parents, communities. What emerges is the importance of connection/relationships and the need for training of school social workers responding to highly publicized, targeted crises such as school gun violence. Relevant literature on crisis response planning exists; however, given the rates of STS among emotional first responders, these protocols may be further revised to include focus on help for the helpers. Self-care for emotional first responders should be reimagined and be a prominent component of any response and recovery plan.

Social work education also needs to reexamine MSW curriculums to consider offering Psychological First Aid and basic trauma knowledge to their school social work students. It is critical for the legitimacy of the social work profession that social work students are able to identify the interventions utilized and the theoretical reason for their use. Finally, social workers are trained to have the ability to work from a relational perspective within large systems. An important aspect of healing from trauma is reconnection, a concept that social workers embrace in their work. Given the needs of a traumatized communities, school districts are advised to include social workers in all systems levels of response planning.

APPENDICES

Appendix A: Email Recruitment Letter

Appendix B: Social Media Recruitment Flyer

Appendix C: Consent for Participation

Appendix D: Interview Guide

APPENDIX A

Recruitment Email to School Social Workers

Dear School Social Worker,

My name is Kerry Doyle, and I am a doctoral student at the University of Pennsylvania School of Social Policy and Practice. As part of my dissertation research, I am conducting a study to examine school social workers' experiences of targeted gun violence in their schools. I am also on the faculty at the Suzanne Dworak-Peck School of Social Work at the University of Southern California, and I have many years of practice experience in K-12 schools.

The purpose of the study is to learn how social workers are responding to targeted gun violence in the hopes of preparing future social workers for such events I am writing to invite you to participate in this study because you were employed in a K-12 school at the time the school experienced targeted gun violence. I am interested in learning about your experiences being a member of the impacted school community while also providing services to that community in the aftermath of the attack.

This study has been approved by the Institutional Review Board at the University of Pennsylvania.

If you decide to participate, I will ask you to complete two 45-60 minute interviews via Zoom at a time and location that are convenient to you. Given the sensitivity of this research, I designed the interview to focus on your role as a school social worker and the services you provided to the school community after the incident. I will not ask direct questions about the events of that day; however, I would be honored to learn about that day should you choose to disclose your experiences.

If you are interested in participating or you have any questions about the study please feel free to contact me at XXXXXXXXXXXXXXXX.

Thank you,

Kerry Doyle, MSSW

DSW Candidate

UPenn School of Policy & Practice

APPENDIX B

Facebook/Social Media Post

Are you a school social worker who experienced targeted gun violence at your school? Do you know a school social worker that experienced this type of violence at their school? Would you be willing to participate in a study to discuss your experiences providing services to the K-12 community in the aftermath of the violence?

You may be eligible to participate in this study if:

- You worked at a K-12 school at the time targeted gun violence occurred in the district
- You remained employed by the district for at least one year after the incident
- You have a Master of Social Work degree from an accredited school of social work

Your participation will include?

- Completion of two individual Zoom interviews of approximately 45-60 minutes each
- Possible follow-up communication before December 2021 with additional questions or clarification

What will you receive for participating?

- Your choice of a $15 Amazon or $15 Panera gift card.

What does the researcher hope this study will achieve?

Findings from this study will inform educational programs for Bachelor- and Masters level school social work students so they are prepared to address targeted gun violence in their work.

If you are interested in participation, please contact Kerry Doyle at XXXXXXXX**Thank you!**

APPENDIX C

UNIVERSITY OF PENNSYLVANIA
RESEARCH SUBJECT
INFORMED CONSENT FORM

Protocol Title:	Lessons Learned from School Gun Violence: A Qualitative Study of School Social Worker's Experiences Providing Crisis Response
Principal Investigator:	Allison Werner-Lin, PhD, LCSW 3701 Locust Walk, Caster C16 Philadelphia, PA, 19104 XXXXXXXXXXXXXXX XXXXXXXXXXXXXX
Co-Investigator	Kerry Doyle, LICSW, DSW Student XXXXXXXXXXXX XXXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXXX
Emergency Contact:	XXXXXXXXXXXX XXXXXXXXXXXXX

Research Study Summary for Potential Subjects
You are being invited to participate in a research study. Your participation is voluntary, and you should only participate if you completely understand what the study requires and what the risks of participation are. You should ask the study team any questions you have related to participating before agreeing to join the study. If you have any questions about your rights as a human research participant at any time before, during or after participation, please contact the UPenn Institutional Review Board (IRB) at (215) 898-2614 for assistance.

This research study is being conducted to learn about the experiences of school social workers that have worked within or been contracted by schools that have experienced targeted gun violence. This study will explore how this experience impacted your work with students, faculty, and the school community. We are seeking to understand your experiences so it can be of benefit to other school social workers.

If you agree to join the study, you will be asked to complete the following research procedures:

Participants will be asked to participate in two Zoom interviews lasting 45-60 minutes each.

Your participation in this study would be of potential benefit to other school social workers or social workers contracted by schools as well as to the design of social work education. The most common risks of participation are potential emotional discomfort during the interviews; however, participants can end the interview upon request.

If you are interested in participating, a member of the study team will review the full information with you. You are free to decline or stop participation at any time during or after the initial consenting process.

What is the purpose of the study?

The purpose of the study is to learn more about the experiences of school social workers who have worked within or been contracted by schools that have experienced gun related violence. This study will explore how this experience impacted their work with students, faculty, and the school community.

Why was I asked to participate in the study?

You are being asked to join this study because you are either a school social worker that has been employed at a school at the time of gun related violence or contracted in the aftermath of the shooting and you provided social work services to students, faculty, and the school community following the event.

How long will I be in the study?

The study will take place over a period of twelve (12) months, May 2021 to April 2022. Your participation in this study includes time spent in individual interviews and any follow-up contact from the researcher, each of which you are consenting to by signing this form. The researcher may contact you after you complete both interviews to ask a question or clarify something you said, but if that is not necessary, your study participation ends when you complete your interviews. By signing this form, you are consenting to participate in two interviews using a zoom platform and to possible follow-up by the researcher to clarify responses or ask additional questions.

Where will the study take place?

For interviews, participants are asked to download Zoom and select a physical location of their choosing that would provide privacy and quiet for the interview. You may ask the researcher to work together with you to select a suitable location.

How many other people will be in this study?

We aim to recruit 15 school social workers.

What will I be asked to do?

In the interviews, you will be asked a series of questions about your experience as a school social worker providing services after gun violence has occurred in the school where you are or were employed.

What are the risks?

The risks associated with participation in this study are minimal. One potential risk is that you may experience emotional discomfort when you discuss what you learned about providing social work services around this shared trauma. If these feelings become unmanageable for you or you are otherwise distressed, the researcher will offer to stop the interview. The interviewer is a licensed clinical social worker with experience in assessment and crisis intervention. Assessment, support, and referral information for will be offered and available to you at no cost, including some available 24 hours a day and seven days a week. You may also request the interviewer pause or terminate the interview at any time.

How will I benefit from the study?

There is no direct benefit to you. However, your participation could help researchers, educators, and social workers understand important knowledge and skills that school social workers could utilize post crisis, which can benefit you indirectly. In the future, findings from this study may help other school social workers to offer crisis and support services after traumatic events in the school where they are employed.

What other choices do I have?

Your alternative to being in the study is to not be in the study.

What happens if I do not choose to join the research study?

You may choose to join the study or you may choose not to join the study. Your participation is voluntary. There is no penalty if you choose not to join the research study. There are no negative consequences to choosing not to participate.

When is the study over? Can I leave the study before it ends?

The study is expected to end in April of 2022 after all participants have completed two interviews and any follow up contacts are completed. The study may be stopped without your consent for the following reasons:

- The researcher feels it is best for your safety and/or health-you will be informed of the reasons why.
- You have not followed the study instructions or are ineligible.
- The primary researcher, the sponsor or the Institutional Review Board (IRB) at the University of Pennsylvania can stop the study anytime

You have the right to drop out of the research study at any time during your participation. There is no penalty or loss of benefits to which you are otherwise entitled if you decide to do so. Withdrawal will not interfere with your future work as a school social worker.

If you no longer wish to be in the research study, please contact the co-researcher, Kerry Doyle, at XXXXXXXXXXXXX and take the following steps:

Speak with Kerry Doyle or leave a voicemail at the phone number listed above explaining that you would like to withdraw from the study. You do not need to provide a reason; however, if

you are willing to share the reason, the researchers would welcome it. There will be no negative consequences for choosing to withdraw from the study.

How will my personal information be protected during the study?

We will do our best to make sure that the personal information obtained during the course of this research study will be kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name, the school district name or identifying information, and other personal information will not be used. You will be asked to select a pseudonym prior to the start of the interviews. The Institutional Review Board (IRB) at the University of Pennsylvania will have access to the study records. An exception to confidentiality is if you report child or elder abuse or neglect, or if you report suicidal or homicidal ideation or intent to the research team. Any information about child or elder abuse or intent to harm yourself or others will be reported to the authorities, as required by law. Additional steps include:

- Every attempt will be made to avoid having identifying information in the digital recordings of the interviews. You will be asked to select a pseudonym at the beginning of interview. Demographic information will be scanned and uploaded to a password-protected computer by co-researcher, Kerry Doyle.

- All digital recordings and other study related electronic documents such as transcribed interviews will be password protected with only the researcher Kerry Doyle and her dissertation chair, Allison Werner-Lin, PhD having access. Both of these researchers will maintain and adhere to only the highest standards of confidentiality related to your participation in this study.

- All hard copy study related materials will be scanned and uploaded to a password protected computer.

- A pseudonym selected by the participant will be used to identify the participant's interview recordings and transcriptions will be established further protecting confidentiality.

- All study recordings will be destroyed at the conclusion of this study.

What may happen to my information collected on this study?

If information from this study is published or presented at conferences, your name, the school district name or identifying information, and other personal information which could identify you such as your place of work, will not be used. Your information will be de-identified. De-identified means that all information that could reveal the identity of a participant and the school district in which they worked have been removed. The information could be stored and shared for future research in this de-identified fashion. It would not be possible for future researchers to identify you as we would not share any identifiable information about you with future researchers. De-identified data can be shared without seeking additional consent in the future, as

permitted by law. The future use of your information only applies to the information collected for this study.

Electronic Medical Records and Research Results
Medical records are not part of this study.

What is an Electronic Medical Record and/or a Clinical Trial Management System?
An Electronic Medical Record (EMR) is an electronic version of the record of your care within a health system. An EMR is simply a computerized version of a paper medical record.

What happens if I am injured from being in the study?
Sustaining an injury as a result of participation in this study is highly unlikely; however, if you are injured as a result of participation, please notify the researcher, Kerry Doyle, as soon as possible. Ms. Doyle will make every effort to assist you in accessing medical care to treat your injuries directly resulting from participating in this study such as calling 911 emergency service, notifying a family member or friend, or making other appropriate efforts. The health care provider accessed may bill your insurance company or other third parties, if appropriate, for the costs of the care you get to treat the injury, but you may also be responsible for some of the costs.

There are no plans for the University of Pennsylvania to pay you or give you other compensation for the injury. You do not give up your legal rights by signing this form.

If you think you have been injured as a result of taking part in this research study, tell the person in charge of the research study as soon as possible. The researcher's name and phone number are listed in the consent form.

Will I have to pay for anything?
There are no costs to you for participation in this study.

Will I be paid for being in this study?
As a study participant you will receive a single $15 gift card to Amazon.com for your participation. Gift cards will be offered when both interviews have been completed.

Who can I call with questions, complaints or if I'm concerned about my rights as a research subject?
If you have questions, concerns or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Principal Investigator listed on the first page of this form. If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the IRB at (215) 898 2614.
When you sign this form, you are agreeing to take part in this research study. If you have any questions or there is something you do not understand, please ask. You will receive a copy of this consent document.

_____	_____	_____
Printed Name of Subject	Signature of Subject	Date

APPENDIX D

Interview Guide

The purpose of this study is to understand the experiences of school social workers that have experienced targeted gun violence event at their school. I will ask participants what they learned from the experience of providing crisis response and support services to students, teachers, parents, and the school community. In addition, I will ask about the ways in which social workers like you were impacted professionally and personally by the violent event. The interview will be conducted using a semi-structured format so that this should feel like a conversation. I will follow your pacing. The dissertation will be available to you if you are interested and choose to request a copy. Your participation will include two scheduled interviews. This allows you to expand on topics we discussed in the first interview and enables me to ask follow-up questions in the second interview to be sure I understand your story. Each interview will last approximately 45-60 minutes or end earlier if you request to end it.

My intent is to focus on your experience regarding services provided in the aftermath of the shooting. I do not plan to ask you to describe experiences of the shooting itself; however, if at any point during our conversations, today or next time, if you want to share parts of your experience of the shooting, please feel free to stop wherever we are in the interview and tell me your story.

As indicated in the consent form, your participation is voluntary and you can terminate your involvement in this study at anytime. Your personal identification information will remain confidential and you may choose a pseudonym for use with your data.

Pseudonym:_____

Please remember that I am a mandated reporter therefore, I am required by law to disclose any harm to yourself and/or others to keep you safe. The consent form we reviewed and you signed discussed how the interviews will be transcribed, de-identfied, and stored to protect your privacy and confidentiality. I am also available if you have any questions at any point during or after the interview.

Do you have any questions before we begin the first interview?

Section 1: In this section, I am interested in learning about your preparation for school social work and any training in crisis or trauma work that was part of your learning.

(1) Tell me about your experiences as a school social worker prior to the shooting?

   a. Could you describe how you learned the role and skills of a school social worker?

   b. Did your MSW curriculum have school social work related courses or

curriculum?

c. In what ways did your social work education influence your knowledge of trauma, trauma related interventions, and crisis response? Did you have course work in trauma and/or crisis response?

d. Were there other ways you gained trauma or crisis intervention knowledge outside of your MSW education?

e. Can you share any trauma related or crisis intervention knowledge that you have specifically found to be helpful in your role as a social worker in general prior to the shooting?

Section 2: In this section, I'm interested in learning what parts of your role have shifted, if any, since the shooting.

(2) Tell me about the composition of the community your school serves.

(3) Tell me about your experiences as a school social worker since the shooting?

a. How has your social work role and responsibilities been impacted? What are your primary responsibilities now as the (one of several) school social worker(s)? Were there any new, expanded, or additional responsibilities in the aftermath of the shooting?

b. In what ways have students and families, teachers, administrators, and the community been impacted by the shooting? How did their reactions and needs shape your work, if at all?

c. How and in what ways dud your role or work with students and the community shift over time? What or who informed these changes in your role or interventions?

d. In what ways did you feel prepared to respond? In what ways did you feel less prepared?

e. What do you wish you had known about trauma and crisis response related interventions prior to the shooting?

f. Are there ways in which social media has shaped the school/community response or reaction in the aftermath? Have these influenced your role or work in anyway?

g. Are there ways in which the media attention (or lack thereof) to the shooting shaped your role or work within the school and/or community?

h. Has the school experienced other crises or trauma that have impacted the school or community? This might include other experiences of violence, deaths related to the pandemic or other illness/trauma either within the school building or within the community (student suicide, natural disasters, etc)?

i. Do students, administrators, families, or social workers like you have access to other supportive resources to address the impact of the school shooting?

Section 3: As a member of this community, you experienced the shooting in your own way. In this section. I'm interested in learning about how you managed your own reactions and emotions regarding the shooting while balancing/providing care to respond to the needs of the school and community.

(4) How has this trauma impacted you as an individual and community member outside of your social worker role?

a. Can you tell me about any resources you found helpful and accessed? Did the support, amount and type, meet your hoped expectations?

b. What resources do you think would be most helpful in response?

c. How have you managed providing support to others around this and maintaining your own well-being? Did you feel like you could show an emotional response in the professional space?

d. Describe any signs of secondary traumatic stress or compassion fatigue you noticed in yourself or other social workers since the trauma?

e. What advice would you give to a social worker whose school also experienced a similar targeted gun violence event?

(5) Is there anything important to your experience that I haven't asked you about?

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